BRITISH MEDICAL AND HEALTH POLICIES IN WEST AFRICA C1920 - 1960

BY

FLORENCE EJOGHA NKWAM

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ProQuest LLC.
789 East Eisenhower Parkway
P.O. Box 1346
Ann Arbor, MI 48106 – 1346

Dedication

To my husband and children

ABSTRACT

This thesis deals with the parts played by the Colonial Office and colonial governments in providing medical and health services in British West Africa. The themes addressed are: the provision of medical and health services; the organization of Colonial medical research; and the recruitment of medical officers.

The inter-war period saw the development of a number of medical institutions established in government centres by the various colonial administrations. The provision of health care facilities in the rural areas was the responsibility of local authorities. During world war two, the Colonial Advisory Medical Committee produced for the first time a statement of policy on medicine and health for the Colonial Empire. This emphasised not only the provision of curative facilities but also the provision of preventive health care services.

Apart from the provision of medical and health facilities, efforts were also made to stimulate interest in medical research. Medical research in British West Africa before WWII was carried out as part of the routine duties of Colonial Medical Departments. However, the Colonial Medical Research Committee, set up in 1945 by the Colonial Office, was to exert considerable influence on research policy in the region. The committee, which was dominated by the Medical Research Council favoured fundamental research. However, fundamental research was considered not relevant to the immediate needs of colonial

peoples. Instead, there was established a medical research organization, with emphasis on applied research and the investigation of the most prevalent diseases in West Africa.

Meanwhile, between the wars, the Colonial Office tackled the problem of recruiting medical officers by creating the post of Chief Medical Adviser and by the amalgamation of the colonial medical services (CMS). Upto the outbreak of the war, however, the Office was still unable to meet the personnel requirements for the CMS. This problem was further aggravated with the creation in 1948, of the National Health Service. The end of WWII also saw an increase in international cooperation. United Nations specialised agencies such as the World Health Organization began to take an active interest in the health problems of African peoples.

ABBREVIATIONS

AMO:	African Medical Officer
ATMH:	Annals of Tropical Medicine and Hygiene
ATMP:	Annals of Tropical Medicine and Parasitology
BELRA:	British Empire Leprosy Relief Association
BMA:	British Medical Association
BMJ:	British Medical Journal
CDA:	Colonial Development Act
CDAC:	Colonial Development Advisory Committee
CDF:	Colonial Development Fund.
CAMC:	Colonial Advisory Medical Committee
CAMSC:	Colonial Advisory Medical and Sanitary Committee
CDPHC:	Colonial Development Public Health Committee
CD and WA:	Colonial Development and Welfare Act
CMA:	Chief Medical Advisor
CMRC:	Colonial Medical Research Committee
CMS:	Colonial Medical Service
CCTA:	Commission de cooperation Technique pur l'Afrique
Cmd:	Command paper
CUP:	Cambridge University Press
FAO:	Food and Agricultural Organization
GMC:	General Medical Council
HMSO:	His or Her Majesty's Stationery Office
IMS:	Indian Medical Service
INA:	Ibadan National Archives
IOPH:	International Office of Public Health
ISC:	International Sanitary Convention
IUP:	Ibadan University Press
JAH:	Journal of African History

JTMH:	Journal of Tropical Medicine and Hygiene
LSTM:	Liverpool School of Tropical Medicine
LSHTM:	London School of Hygiene and Tropical Medicine
M.O.:	Medical Officer
MOH:	Medical Officer of Health
NHS:	National Health Service
ONA:	Overseas Nursing Association
OUP:	Oxford University Press
PRO:	Public Record Office
RAMC:	Royal Army Medical Corps
TDRF:	Tropical Disease Research Fund
TRSTMH:	Transactions Royal Society of Tropical Medicine and Hygiene
UNICEF:	United Nations International Children's Emergency Fund
UNRRA:	United Nations Relief and Rehabilitation Association
WAACMR:	West African Advisory Committee for Medical Research
WAC:	West African Council
WACMR:	West African Council for Medical Research
WAMS:	West African Medical Staff
WHO:	World Health Organization

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PREFACE

The opportunity to undertake postgraduate research in African history presented itself in 1983 when I joined my husband, who was then undergoing his Fellowship training in surgery, in Britain. As a result, information for the thesis is based primarily on materials from British Archives. However, in October 1985, I undertook a brief visit to the Nigerian National Archives, Ibadan.

The idea of doing a thesis on health and medicine in Africa was conceived in October 1983, during a discussion with Professor Gray, Head of the History Department, School of Oriental and African Studies. On reading a few of the available literature I discovered that there was still scope for research on various aspects of the subject. The study of health and medicine in Africa is a relatively new field of historical scholarship and consequently much of the literature has tended to concentrate on the outbreak of epidemic diseases and the epidemiology of endemic diseases. One approach to this kind of study had been to examine the relationship between changing human environments and the spread of diseases. There have also been localised studies of medical services. Ralph Schram's work on Nigeria is descriptive rather than analytical and makes no attempt to evaluate the social impact of medical services though it provides useful material on the medical role of missions.[2] Ann Beck's study of East Africa pays more attention to the role of governments, but makes little reference to metropolitan initiatives. The only study to focus on these

is Gale's thesis on official health policy in British West Africa.[4] This considers the problems of the colonial medical service in the region, its recruitment policies, particularly as they affected European and African medical officers and its impact on African society. However, the study ends in 1930 and relies very heavily on secondary sources. Only recently, a new volume on health and disease, edited by David Arnold, was published. In this volume the contributors see medicine and disease as describing a relationship of power and authority, between rulers and ruled: the ultimate aim being an appraisal of the nature and consequently of imperialism itself.[5]

The present study sets out to examine the development of medical and health services in British West Africa between 1920 and the advent of independence. It focuses on Colonial Office initiatives, the role of colonial governments and that of the West African Medical Service. Three main themes are examined first, the shift of emphasis from a colonial medical policy geared almost entirely to the treatment of expatriates to one which began to take an interest in the health problems of the indigenous population and its accompanying problems. Second, colonial medical research; and third the problem of recruitment for the colonial medical service. The study also examines how changes in the international scene (largely the results of world war II) affected medical and health problems in Africa: attention is paid to the role of inter-colonial collaboration and the activities of WHO and FAO.

Before WWI the provision of medical and health services in the colonial empire was directed exclusively towards expatriates. Initially, official policy in British West Africa had been to maintain the health of Europeans. To this end, the fight had been directed against specific diseases. The best-known and most lethal of these at the time was malaria. For malaria, quinine was prescribed as both a curative and preventive measure. Efforts were also directed at eliminating the breeding places of the anopheles mosquito. Most of the west coast of Africa had already been categorised as an endemic malaria zone. With these measures, however, it was hoped that eventually the spread of the disease could be checked, particularly its spread to the European residential areas.

The medical and health policy focused on Europeans changed drastically in the 1920s. A series of epidemics alerted colonial authorities to the health problems of the people they governed. Their outbreaks were largely a result of improved communications and overcrowding in towns. To ameliorate the situation, a number of sanitary reforms were instituted, e.g. the provision of pipeborne water (mostly in capital towns), town planning, swamp reclamation and building of drains. Meanwhile, these epidemics had also prompted colonial governments to create networks of dispensaries, mostly in rural areas and staffed by Africans.

In spite of these developments, what was achieved in the 1920s was very limited. Colonial governments at the time were primarily concerned with the prohibition of abuses such

as alcoholism and slavery and the implementation of transport schemes which it was hoped would enhance economic development.[6] Most officials, however, assumed that colonial rule would last a long time and the immediate problem was to develop the economic potential of the colonies while the social welfare of the people was looked upon as a complex and long-term matter.[7]

The world economic slump in and after 1929 had severe repercussions on the colonial territories. The steep fall in commodity prices resulted in losses of revenue by the colonial governments with the result that there were severe cuts not only in administrative services but also in the limited social services which had been built up in the 1920s. However, these did receive some support from the modest funds made available under the Colonial Development Act of 1929. Such support was promoted by the Colonial Development and Public Health Committee (CDPHC) which in 1930 remarked:

> If the productivity of the African Territories is to be fully developed and with it the potential capacity of these territories to absorb manufactured goods from the U.K., it is essential that the standard of life of the native should be raised and to this end the eradication of disease is one of the most important measures.[8]

This increasing interest in the welfare of the colonial peoples by the Colonial Office could be seen as a reflection of the current climate of opinion in Britain, where the relationship between the welfare of the worker and his economic output was being increasingly recognised.

The development and expansion of medical and health services called for large increases in the numbers of medical and subordinate staffs. Throughout the colonial period, one of the greatest problems that faced the colonial office was the problem of obtaining adequate numbers of qualified medical officers and nurses for the colonial medical services. The difficulties experienced in recruiting such people made it necessary to train and employ more Africans. The need to employ more Africans became even more acute after World War two as a result of constitutional advances in some colonial territories and the establishment in Britain of the National Health Service, which provided for the first time pensionable appointments for medical officers and nurses.

Meanwhile, efforts were also being directed to promote medical research in the colonies. The central institutions for colonial medical research were the London and Liverpool Schools of Tropical Medicine. These were established towards the end of the 19th century in order to provide specialist training and research. Some medical research institutions were established by colonial governments, but these were primarily engaged in routine pathological work. As a result of financial constraints little or no original research was conducted in British West Africa. However, the Colonial Development Act of 1940 for the first time authorised funds for research in the colonies.

Another feature of the post WWII period was that the specialised agencies of the United Nations began to take

particular interest in the health problems of colonial peoples. The activities of the WHO and the FAO are particularly relevant to health problems in Africa.

Two stages may be discerned from this review: the pre-WWII and post WWII periods. The pre-WWII period deals with the complacent years: years when policy was ad hoc and based on expediency. By the close of the inter-war period, the Colonial Office had become acutely aware of the need to rationalise its policy in the colonial empire. Hence the passing of the Colonial Development and Welfare Act of 1940.

Published and unpublished official documents and correspondence located in Britain constitute the major sources for this study. The unpublished materials include original correspondence between the Colonial Office and colonial governments, sessional papers and confidential prints. The official publications include parliamentary publications, Colonial Office lists, Colonial reports and annual medical reports. Literature on the subject was also provided by colonial officers, who in one way or the other were involved in the colonial medical services and have left personal accounts of their experiences. Such reminiscences have recently been compiled end edited by E. E. Sabben-Clare and others.[9] Personal papers in Rhodes House, Oxford have been used. The London School of Hygiene and Tropical Medicine has massive collections of Colonial Medical and Sanitary Reports[10] and reports of the Health Division of the League of Nations, the World Health Organization and the Food and Agricultural Organization.

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10. These have recently been moved to the library of the Wellcome Tropical Institute in London.

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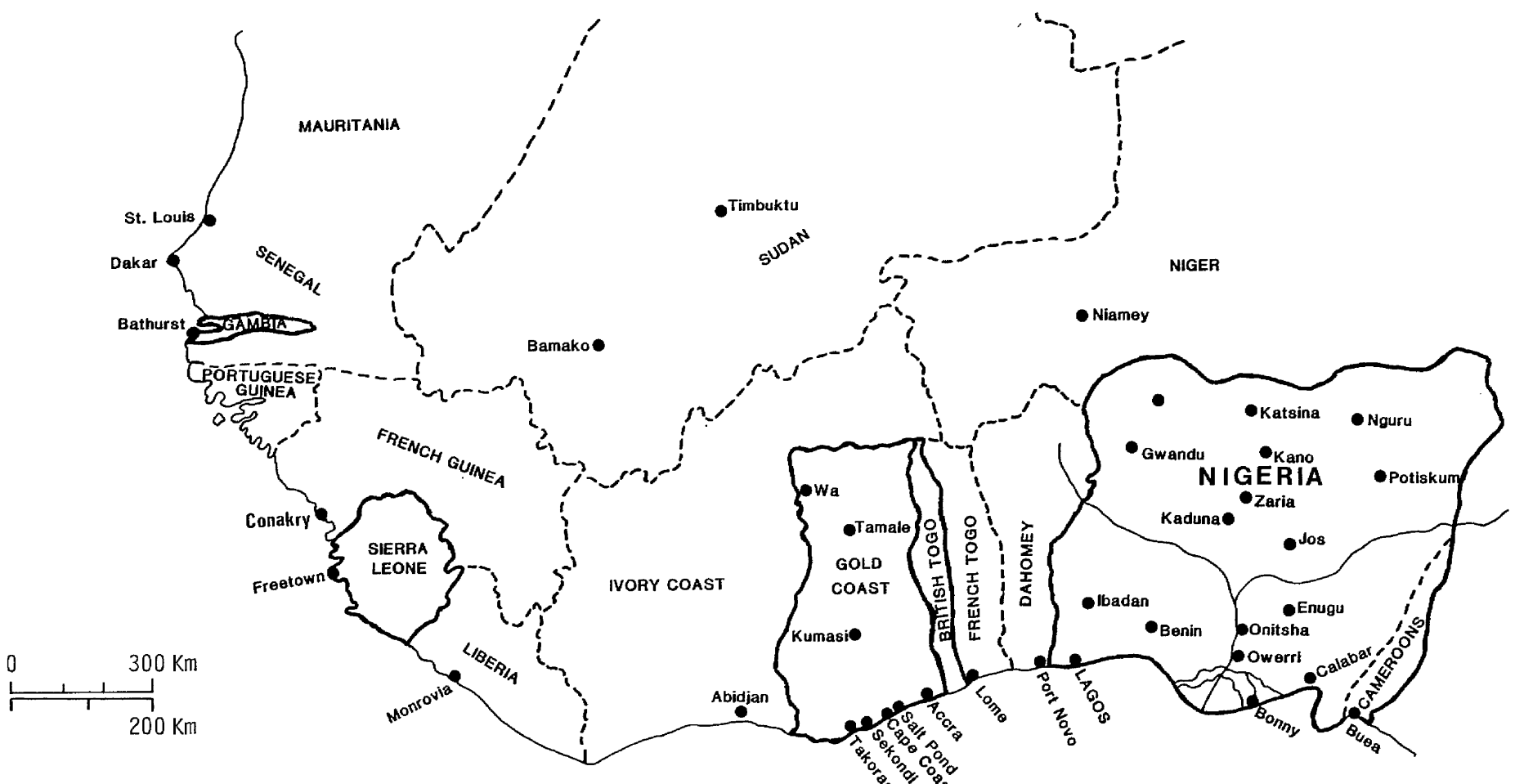
F. E. Nkwam

London, 1988

MAP 1

MAP OF WEST AFRICA SHOWING AREA OF STUDY (1935)



CHAPTER ONE

THE PROVISION OF MEDICAL AND HEALTH SERVICES BETWEEN THE WARS

In British West Africa the 1920s saw a gradual movement towards the assumption of government responsibility for public health. By the end of the 1920s considerable progress had been made in providing medical facilities for the benefit of the general population. In spite of this progress however the inter-war years still witnessed appalling health conditions amongst the indigenous population. Until the late 1920s most official reports stated that 'the general health of the natives was good' or 'satisfactory'. In a few exceptional cases it was said that 'the general health of the natives compares unfavourably with previous year'. Some medical officers of course, were aware that their contact with the indigenous population was too limited to permit making any such sweeping statements. The satisfaction about the general health of the 'natives' vanished when medical officials began to realize the spread of sleeping sickness, yaws, leprosy, tuberculosis, cerebro-spinal meningitis, small pox, dysentery and plague as well as the helminthic diseases. Most of these diseases were endemic in British West Africa but at one time or another some assumed epidemic proportions.

MAJOR DISEASES

Malaria - Malaria is the most common disease in tropical Africa. The malaria parasites are transmitted to man by various species of the anopheles mosquito. Of these, the principal is anopheles gambiae, found throughout tropical Africa. A. gambiae breeds prolifically in a great variety of pools of water. Annual medical reports from West Africa indicate that malaria was the leading cause of African illness and mortality. Indeed, it is clear from modern research that malaria was primarily responsible for the high infant death rates which prevailed in West Africa.

Sleeping sickness - The records of medical writers during the 19th century and the retrospective enquiries made by later writers leave no doubt that sleeping sickness had existed in West Africa and indeed in the whole of tropical Africa for hundreds of years.[1] There are two varieties of sleeping sickness - one caused by Trypanosoma Rhodesiense and the other by Trypanosoma Gambiense. The former is a rapidly fatal infection carried from game animals to man by the tse-tse fly - glossina morsitans. The sufferer is taken ill soon after infection. This variety is most prevalent in East Africa.

In contrast, Trypanosomiasis Gambiense, often gives rise to few or no symptoms for a year or two after infection. For most of this time the subject's blood is infectious to other tsetse flies, so that one case of gambiense sleeping sickness is capable of spreading the infection over a vast area.[2] Gambiense sleeping sickness can therefore be an epidemic disease, its spread limited to climatic conditions suitable to the fly, The fly thrives in humid climatic conditions afforded by the forest zones of West Africa and in the savannah along rivers and streams. The Gambiense is the most prevalent in West Africa.

Before 1900 the West African situation was fairly static, many endemic foci were present but epidemics were unusual. However, the pacification and development of this region - a direct result of British imperialism - produced

the conditions, previously absent, favourable to the increased spread of sleeping sickness to really epidemic proportions, and between 1920 and 1940, there were serious sleeping sickness epidemics in West Africa.

The history of cerebro-spinal meningitis in Africa is not clear. The earliest reports of the disease concern Northern Nigeria and the Sudan in the last decade of the 19th century.[3] The disease subsequently appeared, not only in local outbreaks but also in devastating outbreaks across the southern fringes of the Sahara. In this region therefore, it was said to be not a new disease. Cerebro-spinal meningitis is a highly contagious disease associated with crowded unsanitary conditions as when people huddle together at night during the dry season in the Northern Provinces of Nigeria and the northern territories of the Gold Coast. Cerebro-spinal meningitis is thus a seasonal disease. The increased mobility created by colonial administrations in West Africa enhanced the spread of the disease over larger areas.

That venereal diseases (syphilis and gonorrhoea) were rife in British West Africa cannot be disputed. [4] Syphilis is caused by a spirochete known as Treponema pallidum while gonorrhea is caused by bacteria, Neisseria gonorrhoeae. It has generally been argued that V.D. was foreign to tropical Africa[5] and was introduced to the region following the region's increased contact with Europeans and Arabs. By the late 19th century both syphilis and gonorrhea had become endemic in West Africa.[6] In British West Africa V.D. was

most prevalent in the cities, which then were mainly located on the coast. In 1927, C.E. Reindorf (African Medical Officer) reported that his records at the V.D. clinic in Accra, Gold Coast showed that over seventy-five percent of the population of the town between the ages of eighteen and forty-five suffered from some form of V.D.[7] With the growth of towns and increased communication networks and the introduction of wage labour the disease became very widespread in West Africa.

Dysentery was also very common, especially in the rural areas of West Africa. It was caused either by contaminated water or by food which was infected by flies.

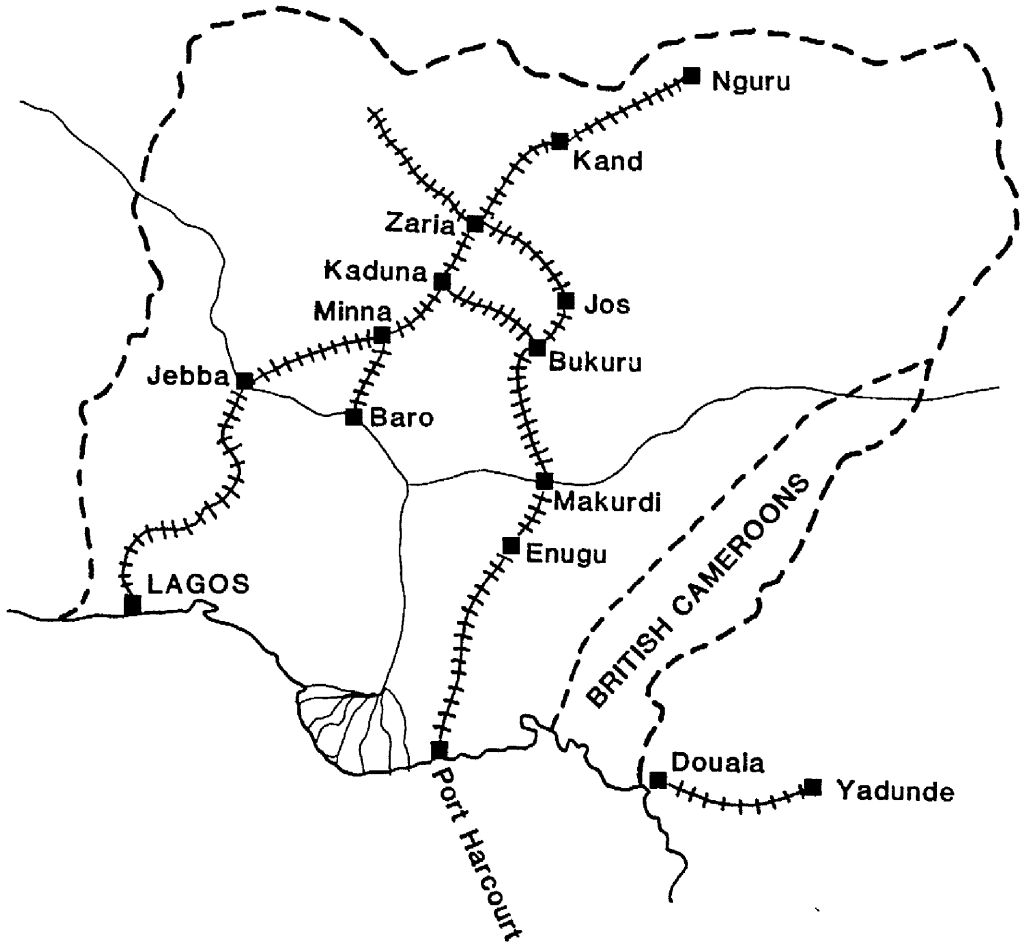
Smallpox had been prevalent in West Africa before the introduction of colonial rule but its spread was facilitated towards the end of the 19th century when the British opened up the hinterland.[8]

INCREASED INTERCOMMUNICATION

Colonial administrations in British West Africa had realized early on that better communications were essential for the economic development of the region and by the last decade of the 19th century they had begun to improve the infrastructure. The transport revolution started off with the construction of harbours followed by the construction of railways and roads. In the Gold Coast the railway line from Sekondi on the Coast to Kumasi in Ashanti was begun in 1898. The line reached the mining centres of Tarkwa in 1901

MAP 2

Map of Nigeria showing railway lines, 1930



and Obuasi in 1902 and by 1903 had been extended to Kumasi. Branches of this line reached Prestea in 1911 and Kade in 1927. Another line to Accra was completed to Koforidua in 1915 and to Kumasi in 1923.[9] In Sierra Leone the main line ran from Freetown to Pendembu, a trading centre near the boundaries of Liberia and French Guinea; a branch line ran from Boia to Kanabai serving the northern provinces. The construction of the main line was began in 1896, but did not reach Pendembu till 1908.

In Nigeria the Lagos to Ibadan line was completed between 1896 and 1900. This line was extended to Jebba in 1909 and to Kano in 1911. The line was joined at Mina by an extension from Lagos in the south and ran through the Niger-Benue valley at Jebba. A branch line was constructed in 1915 from Zaria to Bukuru on the Bauchi Plateau among the tin fields. This line was meant to serve the mining industry. The eastern division of the railway began at Port Harcourt after the discovery in 1909 of coal deposits at Udi near Enugu. The line passed the coal field of Enugu and reached the Benue at Makurdi. It was completed in 1927 when the line was extended to Kaduna.

Unfortunately most of the railway lines in Nigeria passed through the Niger-Benue region an area which had been classified as a sleeping sickness endemic zone.[10] Increased intercommunication brought about by improvements in transport facilities meant that the disease could be carried by infected patients to areas which although

previously free from sleeping sickness harboured plenty of fly. The sleeping sickness problem was further complicated by the employment of labourers for the mining industries. During the 1930s, for example, gold mining camps were established around Abuja and Mina; these created local conditions for the intensification of transmission. Studies undertaken of Sleeping Sickness in these mines varied from 5.0 to 15.0 percent in places where village indices were not more than 1.5 percent.[11] Similarly, in 1935 the Nigeria Government embarked on the relaying of the Kaduna - Mina railway line. Permanent gangs of labourers were employed, drawn from all parts of the country. Not only might they have brought their own local strains of Sleeping Sickness with them, but in working in an endemic zone, healthy labourers contracted the disease, and then infected the tsetse in clean areas as they moved on. According to a contemporary study, there was a twenty percent infection rate among labourers employed on this undertaking.[12] When railroad construction finished, these labourers dispersed, many of them went to work on the gold mines. Labourers engaged in mining tin or gold in the area were particularly liable to infection. In the tin-mining area of Wamba in the Plateau Province, the infection rate among the permanent labourers on the mines was 46 percent.[13]

The extent of motor road construction became significant in the 1920s. Priority was given to roads which served political as well as commercial purposes. In the Gold Coast, however, road construction was chiefly confined to the cocoa-producing areas of the Colony and Ashanti. By the

end of the 1920s a number of communication networks penetrated Ashanti from Kumasi whence roads also diverged to the Colony in the South to Takoradi and the mining areas in the West and to Cape Coast and Accra.

In Nigeria the presence of tin in the Bauchi Plateau necessitated the construction of a road from Loki to Naraguta. The Plateau area was also opened up by a road from Naraguta through the Lee District of Zaria to Rigacikum on the Baro - Kano railway and by a light railway from Naraguta to Zaria.

The opening up of West Africa resulted in a more fluid population. In former times it was unlikely that an epidemic in one part of the territory could reach another before the disease burned itself out. But by 1930 roads and other transport facilities had brought most towns and villages into contact with the outside world. Colonial rule in itself created new economic opportunities and improved transport facilitated the movement of people from distant parts to mines, plantations and the growing urban centres.

THE IMPACT OF URBANIZATION ON PUBLIC HEALTH

Urbanization had far-reaching consequences on the public health of the people of British West Africa. The growth of towns in Colonial West Africa is best expressed in tabular form.

Towns in Nigeria[14]

	1921	1931	Percentage Increase
Lagos	99690	126108	27
Abeokuta	28941	45763	58
Ibadan	238094	387133	63
Kano	94734	97031	94
Zaria	22680	28121	24

The census returns in the Gold Coast for the year 1931 indicated that there was an extensive movement of indigenous population between the various provinces of the country. This internal migration was most marked in the Western Province and in Ashanti, and least evident in the Northern Territories. Demographic change in the Western Province of the colony is specially revealing:

Gold Coast: Western Province[15]

District	1921	1931	Percentage Increase
Ankobra	38071	46173	21.3
Axim	40759	51924	27
Seqwi	26008	42060	61.7
Sekondi-Dixcove	54164	73821	36.3
Tarkwa	44525	60983	37
Aowin	6517	9941	50

The two largest increases, in Segwi and Aowin, could be attributed directly to the development in these areas of the cocoa planting industry, which together with improvement in transport, resulted in an influx of strangers.[16] There was also the usual movement of people towards the industrial mining area of Tarkwa District and the settlement of aliens in the Sekondi-Dixcove District, where the development of Takoradi harbour was the major attraction. Similarly, the population of Kumasi Province in Ashanti increased from 149, 114 in 1921 to 172, 196 in 1931, an increase of fifteen percent.

In Sierra Leone the population of Freetown increased from 44,142 in 1921 to 55,509 in 1931; and in the Gambia that of St Mary's Island from 9,227 to 14,370 in the same period.[17]

Urban demographic growth and its accompanying densities and pressures upon air, water and space must be borne in mind if the public health problems of the Colonial Territories are to be appreciated. Shortage of housing, over-crowding and insanitary conditions were major features of most of the growing towns in British West Africa. Most houses were poorly ventilated and accommodated several persons per room, thus increasing the risk of spreading such diseases as tuberculosis. In these towns, latrines and refuse disposal were inadequate, drainage non-existent and contaminated water common. Unhygienic habits did less harm in rural areas, where populations were scattered than among the crowded populations of the towns. Upto the

beginning of the 1930s few urban towns were supplied with public stand-pipes. Supply was commonly restricted to a few hours each day; limited health standards were observed; and there was little or no supervision of the quality of water supplied. Besides many people in towns relied on wells, rivers and other sources that were open to contamination. Polluted sources of drinking water in densely populated areas greatly increased the risk of cholera, amoebic dysentry and diarrhoeal disease.

By 1931, there were in Nigeria complete water schemes in Lagos, Kaduna Lokoja, Markudi, Kano, Katsina and Enugu. Partial water supplies were maintained at Benin, Abeokuta, Calabar, Port Harcourt and the Moor Plantation at Ibadan.[18] From all indications artificial water supplies in Nigeria were fragmentary and concentrated in the towns. Much of the work was undertaken, not as might have been expected by the Public Works Department but by the Geological Department in their hydrological survey of the country.[19] In most areas with partial water supplies wells provided the alternative source of supply. Water obtained from wells was never treated. As late as 1928, there was no provision for the bacteriological and chemical examination of water in Nigeria, not even in connection with the various water supply schemes in existence, though the Director of Public Works, C. L. Cox, stressed that regular bacteriological analysis was essential to establish a standard of purity in water supplies.[20] In the same year a proposal was made to the Colonial Office that a water examiner should be attached

to the Government Analyst Department, whose primary duties would be to make both chemical and bacteriological analyses of water at the initial and experimental stages of any scheme.[23]

In the late 1920s in the Gold Coast only Accra, Sekondi, Takoradi, Cape Coast and Winneba had any pipeborne water supplies.[22] By 1930, the Gold Coast Government, under Sir Ransford Slater began to show concern over the unsatisfactory water supply at Tamale, the administrative head-quarters of the Northern Territories. This had a population of 3,900 in 1921 and 12,941 in 1931. Here the water supply was derived primarily from shallow wells supplemented by streams, most of which were highly contaminated. Consequently, the people suffered to a considerable extent from water borne diseases: in 1930 the medical department at Tamale treated,

205 cases of dysentry
308 of enteritis and 278 of guinea worm[23]

By the mid 1930s the Gold Coast government was also concerned about the links between trypanosomiasis and water supply the Northern Territories. Except where wells had been sunk, the sources of supply in the dry season were from streams used also by domestic animals. Trypanosomiasis was rife, especially in the vicinity of streams and rivers in this area. Hence arose the need to provide alternative water supplies in or near the villages, which would remove the need for people to subject themselves and their animals

to the risk of infection.[24] Freetown waterworks were inaugurated in 1902 and until the late 1920s, it was the only town with pipe-borne water supplies. Even then, it suffered acute shortages during the dry season. In 1928 pipe-borne water supplies were provided at Kailahun, Sumbuya, Masanki (government oil-palm plantation) and Newton (government experimented fruit farm). In the Gambia, as late as 1934 only Lamin in the Protectorate and Bathurst in the Colony had pipe-borne water supply.

Urbanization also increased the problem of sewage disposal. In the Gold Coast in 1930, Accra and Takoradi were the only towns which possessed water carriage systems of sewage disposal. Even these were only small systems connected with public institutions such as the Gold Coast Hospital at Korle Bu, the Prince of Wales College, Achimota, two public latrines in Accra and the European Hospital at Takoradi.[25] All the other government stations were served by pan latrines or salgas (pit latrines). Along the Coast night soil was often simply tipped into the sea.

By 1930, there were 15 public latrines in Freetown accommodating 193 pails. Some residents used pail latrines which were removed by private contract. Altogether about 700 pails were emptied daily into the sea.[26] For a population of over 55,000 this was quite inadequate and human waste was littered in the bushes around the town. By 1935, there were approximately 5,000 cesspits in Freetown of which very few were satisfactory. The majority of these

were in the backyards, quite close to the house and were seldom cleared until a notice was served: 4317 such notices were served in 1935.[27]

The problem of waste disposal was as acute in the Gambia. As late as 1935 it was reported that except at Kuntar - Ur and Bakau no public latrine existed in the Protectorate - not even in Georgetown.[28] In Kuntar-Ur there were just two or three concrete pan latrines. The contents of these were disposed of in the river. In 1935 the method of disposal was changed and the contents were deposited into dug-out pits in the vicinity of the town.

The situation was similar in Nigeria where the pail system was used in the larger coastal towns while pit latrines and the 'bush' were used in the smaller towns and villages. In many of the smaller towns and villages in the northern provinces of Nigeria, drinking water was obtained from wells in compounds. If pit latrines were made near wells invariably they polluted them. Thus officials advised digging pit latrines in compounds and wells about 200 yards beyond a villages.[32] Without an adequate system of excrement removal the subsoil could be saturated, thus not only causing leaching into a water supply but also creating breeding-grounds for flies. Dysentery and some of the helminthic diseases were disseminated under conditions such as these.

THE IMPACT OF THE MINING INDUSTRY ON PUBLIC HEALTH

The problem of housing and general sanitation in British West Africa was further compounded with the development of mines and plantations. In mining areas, clusters of hovels sprang up without proper sanitation. Indeed, it was the public health problems of the mining areas which first brought into focus the public health problems of the rural areas.

Among the British West Africa territories mineral exploitation in the 1930s was most advanced in the Gold Coast where there were five important gold mines (Obuasi, Prestea, Tarkwah, Abbontiakoon and Abosso) and a Manganese mine at Nsuta. After WWI there had been a gradual decline in the industry but it revived in the mid 1930s. Consequently the labour force expanded from 12,500 in 1930 to around 40,000 in 1939.[30] In Nigeria the most important mineral was tin, mined chiefly at Bauchi, Zaria, Kano and Ilorin in the Northern Provinces. Development began in 1910, and expanded after the railway was brought to Naraguta in 1914 and to Bukuru in the following year. In 1930 the tin mines in Nigeria employed a labour force of about 30,072.[31]

In Sierra Leone minerals of economic value were unknown until government geologists discovered important deposits of gold, diamond, platinum and iron ore between 1926 and 1931. After the discovery of diamonds on the banks of the Gbobora River in 1930, an exclusive prospecting licence over the

whole territory was granted to the Consolidated African Selection Trust.[32] In 1933 when the first mine was opened, 1,700 men were employed.[33]

In spite of the large numbers of people employed in the mines, mining companies made little or no effort to provide their labourers with adequate accommodation and sanitation. In the late 1920s on the Nigerian Tin Mines

> 'camp housing consisted primarily of grass thatched huts huddled close together, with a radius of about 4 feet.... They were desperately over crowded with four or even eight sleeping to a hut.[34]

The problem was not only one of housing. There were hardly any facilities for sewage and refuse disposal, for mains water supply or for surface drainage. The sanitary problems in the camps were further aggravated by the growth of free squatter settlements over which mining companies had no control. Conditions in such settlements, as the mining camps, facilitated the spread of V.D., cerebro-spinal meningitis, helminthic diseases yet the companies assumed little or no responsibility for the workers' health.

The need to remedy the situation did not escape colonial governments in British West Africa. In the Gold Coast, The Mining Health Areas Ordinance was passed in 1925. The Governor in Council was empowered to declare mining health areas, make regulations for the areas providing for proper housing, feeding of labourers, the provision of an adequate supply of wholesome drinking water and the observance of all requisite sanitary precautions.[35]

A similar Ordinance was passed in Nigeria in 1929 - this was the 1929 Labour Ordinance. The Ordinance gave the governor in Council the power to make regulations, amongst other things, for the compulsory employment of medical practitioners by employers, the compulsory erection of hospitals by employers, the provision of housing, latrines, drains, incinerators, wells and tanks in mining health areas.[36] From all indications not much was achieved, because, in 1936, discussions took place between the mine and the plantation managements and the Health Authorities regarding medical and health services to the mines and plantations, and the much needed improvement in the housing of labourers and in the sanitation of the labour camps. In order to serve as a guide to the form which health requirements were expected to take, a memorandum was issued by P. S. Selwyn - Clarke (DDMS) to all employers of labour.[37]

In Sierra Leone, until the passing of the Labour Code in 1934, the government did not possess adequate legislation to protect the welfare of the labourer. The Employers and Employed Ordinance of 1934 empowered the governor in Council to declare labour health areas, to fix minimum wages, to make rules concerning medical provision for Labourers, the provision of housing, rations and food and the planning and layout of accommodation in these areas and to impose penalties for the infringement of such rules.[38]

In spite of these guidelines, however, Health Authorities seldom sought to have penalties inflicted for failure to meet moral and legal obligations, preferring to rely on the willing cooperation of managements.

Poverty, overcrowding, malnutrition and dust in mines were positively correlated with tuberculosis. Initially medical opinion was divided on how dangerous tuberculosis was to public health. In the 1930s it became generally agreed not only that the disease was common but that the incidence was on the increase. In the 1930s case mortalities became very high indeed. In the Tarkwa gold mine for example, between 1936 and 1939 out of a total number of 1,222 registered deaths, 309 were attributed to pulmonary tuberculosis, accounting for 25.3 percent of total deaths.[39] Mining areas and urban slums were centres where overcrowding and unsuitable diet prevailed and these were the centres which favoured the dissemination of the disease. The disease was usually spread from these foci to rural areas by returning migrant labourers.

In the 1930s public health officials repeatedly stressed the strong association between poverty and tuberculosis and were convinced that only better living conditions could reduce the prevalence of the disease. The abolition of overcrowded and insanitary areas in towns and mining areas was necessary if the situation was to be brought under control. On tuberculosis in the Gold Coast, H. O'Hara (DDHS) remarked in 1931 that

> When the problem is viewed from all angles, it would appear that the disease can be best dealt with by improving general sanitation and housing rather than by any costly direct expensive institution (i.e. segregation of tuberculosis patients).[40]

Similarly, in 1933 the DMS for Sierra Leone pointed out that the chief hope for curtailing the spread of tuberculosis lay in the gradual improvement of housing conditions and in educating the population in the practical measures necessary to prevent the spread of infection.[41]

The close relationship between the physical environment and good health cannot be doubted. Most of the prevalent diseases in British West Africa were direct results of environmental conditions. Vast problems of sewerage, water supply, drainage and crowded conditions multiplied the risk of infectious and contagious diseases. Enhanced mobility in the 20th century also resulted in the rapid dissemination of disease. The prevalence of these diseases however, increased the awareness of the colonial governments of the need to combat them.

THE STRUCTURE OF THE ADMINISTRATION AND THE PROVISION OF MEDICAL AND HEALTH FACILITIES

Four groups were engaged on services intended to improve the health of the peoples of British West Africa: the Central governments operating through the department of medical and health services; the Native Administrations; the voluntary agencies and a small number of private medical

practitioners. At the head of the medical department was the Director of Medical Services with a deputy director to assist him. The deputy director was usually selected from the health branch of the department. The medical branch dealt with curative side of medicine (mainly connected with medical institutions); While the health branch dealt with the preventive side. The routine functions of the health branch included dealing with insanitary areas and conditions in towns, villages and settlements or private public buildings such as market places, schools, prisons, slaughter houses, shops and various trading places; the disposal of rubbish and nightsoil, the care and maintenance of drainage schemes, reclamation schemes, town planning, latrines and water supplies, quarantine measures in connection with port health work and infectious diseases; the training of sanitary personnel and propaganda to promote knowledge of hygiene. Among its extraordinary duties were measures for dealing with epidemic outbreaks, the care of infectious disease hospitals, and vaccinations and inoculations, as preventive measures.

Until the outbreak of WWI medical services in the region were designed primarily to care for the Europeans and other government officials. As a result, government hospitals and medical staffs were located where government officials were stationed and not necessarily where the bulk of the population lived. However, a series of epidemics in the 1920s served to arouse the awareness of Colonial Authorities to the health problems of the people they governed. In 1924 in Nigeria, a number of diseases began to assume epidemic

MAP 3

Map of Nigeria Showing the Provinces and major towns, 1930

proportions, accompanied by very high mortality. These were cerebro-spinal meningitis, relapsing fever and plague. Cerebro-spinal meningitis had been known to exist for many years in the northern provinces of the territory but the disease increased in intensity in 1922. Relapsing fever was said to have been introduced into Nigeria from the French territory of Dahomey. Its spread from the western portions of Sokoto and Kontagora into the Katsina Emirate and other parts of Kano province became very marked during the third quarter of 1924. From then on, both cerebro-spinal meningitis and relapsing fever, but particularly the latter, prevailed with varying degrees of intensity in the provinces of Sokoto, Kano, Bornu, Zaria, Niger and Bauchi.[42]

In addition, in the Southern Provinces, plague occurred in epidemic form. Although restricted at first to Lagos Island, by 1925, the mainland was also threatened and there were sporadic cases at Agege where the local infection of rats was established. One hundred and seventeen cases of plague with ninety-five deaths were reported from Ijebu-Ode.[43]

In 1926-7, there were serious and more widespread outbreaks of yellow fever throughout West Africa which resulted in the region being placed on international quarantine and the first inter-colonial conference in the region. This was the Yellow Fever Conference held in Dakar in 1928 and attended by both British and French medical authorities.[44]

As a result of these epidemics there were loud out cries from the medical officers who were in close contact with the indigenous population and were thus in a position to understand the need for increased medical and health services. In Nigeria for example, Dr. D. Alexander (DMSS) saw the vast amount of suffering throughout the territory and in 1926 commented that,

> Although we cannot relieve more than a very small fraction of the suffering, it is urgent that this service of the community should be as widely extended as possible.[45]

The outbreak of these epidemics was largely a result of improved communications and urban over-crowding. Hence deteriorating health conditions during the 1920s provoked an expansion of medical and health services in British West Africa. There were increases in the number of medical institutions in the urban centres;[46] in the annual expenditure of the medical departments; in the number of patients treated; and in the number of medical officers recruited.[47] In Nigeria, between 1920 and 1930 Government hospitals increased from 32 to 47 and Mission hospital from 7 to 23. By 1930 these hospitals provided 1,440 beds.[48] The total medical and sanitary staff, Europeans and Africans rose from 595 in 1920 to 1183 in 1930, while in the same period the number of cases treated in medical institutions rose from 50,699 to 462,304.[49]

There were also intensive campaigns to improve the general sanitary conditions of the main colonial towns. In Nigeria the plague epidemic resulted in the establishment in 1927 of a Town Planning Board. This was to become the executive authority for the town planning of Lagos. It had powers to demolish or alter buildings which were insanitary, stopped ventilation or otherwise made other buildings unhealthy, or prevented proper measures from being carried into effect for remedying any nuisance.[50] Under part one of the ordinance the Board had power to prepare Town Planning Schemes and to declare areas to be town planning areas in which they had to take into consideration the alignment of the streets, alteration of existing streets, erection of and demolition of buildings. With the inauguration of the Board, the Nigerian Government considered that a permanent adviser was required to assist in the work of Town Planning in Nigeria in general and Lagos in particular. As a result, A. J. Thompson was appointed Town Planning Officer in January 1928.[51] Similarly, Dr. I. L. Oluwole (AMO) was appointed Medical Officer of Health for the Lagos Town Council.

Other measures adopted included the provision of pipe-borne water, the supply of electric lighting and swamp drainage.

Significant advances were also made in other areas of preventive medicine: schools inspection, child welfare and maternity care. The first child welfare centres in British

West Africa were started in 1924 in the Gold Coast by the Scottish Mission. Initially two such centres were opened: one in Christiansborg and the other in the Ho District, manned by lady medical officers.[52] There was also initiated in the 1920s the periodical inspection of school buildings, sanitary conveniences and surroundings as well as the inspection of school children. However, these measures were concentrated in territorial headquarters: Lagos, Accra and Freetown.

Qualitative and quantitative changes were reflected not only in the work done by the Colonial Medical Departments but also in important changes of organisation in the Colonial Office. From the early 1920s, the Colonial Office began to recognise the importance of medicine and public health from an economic as well as a humanitarian point of view. This recognition was reflected not only in the allocation of more funds from colonial revenues (colonial budgets had to be approved by the Colonial Office) for this purpose but also in an increase in the medical staffs and efforts to attract candidates of a high personal and professional standard to the Colonial Medical Services.

Changes of organization in the Colonial Office were directed both towards linking the medical services of the colonies with each other and towards applying British professional expertise to specific Colonial problems. The Tropical Advisory Medical and Sanitary Committee (TAMSC) was created in 1922 and in 1926 Dr. A. T. Stanton was appointed Chief Medical Adviser to the Colonial Office.[53] In 1927, a

Colonial Medical Research Committee (CMRC) was constituted with the object of bringing research institutions in the colonies into closer touch with research in Britain.[54]

In rural British West Africa, medical and public health facilities had hitherto been provided by Christian missions. With the growing awareness of the medical needs of the rural areas, however, some colonial governments decided to regularise their policy of providing grants in aid of medical missions. In 1927 Thomas B. Adam (Ag. DMSS, Nigeria), in a letter to the Chief Secretary to the government said,

> I think that the time has come when it would be advisable and advantageous to bring all medical work of the missions under the direction and control of Government in the same way as educational work, giving grants where necessary and at the same time demanding a reasonable standard of efficiency in the work done.[55]

This proposal was approved by the Secretary of State for the Colonies, L. S. Amery, in 1928.[56] A similar policy was adopted by J. Byrne, the Governor of Sierra Leone. In 1928 he invited the heads of the Christian Missions working in the Protectorate to cooperate with the Government in providing medical and nursing assistance. He told the missions that the Government would offer adequate subsidies as grants-in-aid, if the missions would undertake medical work and more particularly infant welfare work in the Protectorate.[57] The suggestion was warmly received by the missions.

Meanwhile some native administrations began to play an increasing role in providing medical and health facilities, particularly the establishment and staffing of dispensaries in the rural areas. Thus a large number of the African population began to have access to medical facilities which until then were centred in the urban areas. As early as the first decade of the 20th century, Native Authorities as well as native treasuries had been set up in the northern provinces of Nigeria. By 1928, these had been extended to the Southern Provinces.[58] Those Native Treasuries in Nigeria which were classified as fully organized received 70 per cent of the revenue collected by them, and provided from their own resources a correspondingly wide range of public services, including medical and health facilities. In 1931/32, for example, the percentages for the main items in the estimates for Kano Province and the Northern Provinces in general were:-

	Kano	Northern Provinces[59]
General Administration	48.1	59.97
Recurrent Works and Staff	28.1	19.12
Education	2.6	4.31
Survey	5.2	0.16
Medicine and Health	3.7	4.14
Agriculture	0.8	0.52
Forestry	Nil	0.85
Capital works	12.3	8.01

Indirect Rule in the Nigerian sense was not introduced to the Gold Coast, Sierra Leone and the Gambia until the

late 1930s. In the Gold Coast the native administration was of the laissez - faire variety. The most common local government institution introduced in the Gold Coast were Town Councils and Public Health Boards. Up to about 1925, there were only three Town Councils: Accra, Cape Coast and Sekondi.[60] In 1925 the Kumasi Public Health Board was set up; in 1935 a Sanitary Board was set up for the mining town of Obuasi in Ashanti; and in 1940 a similar Board was set up for the mining area of Tarkwa in the Western Province of the Colony.[61] The implication of this policy was that apart from the limited activities of these Boards, the Central Government of the Gold Coast was responsible for the bulk of administrative duties, instead of sharing them with the Native Authorities.

By 1935 the Gold Coast Government was determined to entrust Native Authorities with responsibility for providing public health services in the rural areas. Arnold Hodson, the Governor, informed Cunliffe-Lister, the Colonial Secretary, that, acting on the unanimous advice of his Executive Council, he had ordered that the sanitation of the Protectorate should be entrusted to the office of the Native Administrative officer, and subject to the advice and supervision of the medical authorities with whom the general responsibility would rest.[62] However, Hodson's proposals brought him into direct conflict with D. D. Duff (DMS) who was in favour of a more direct approach to the problem. Although plans were being made to introduce Indirect Rule to the Gold Coast in the mid 1930s, Duff doubted the possibility of its being implemented on Nigerian lines. He

therefore solicited the advice of W. B. Johnson, his Nigerian counterpart, on how to develop sanitary control under the indirect rule system.[63] In his reply Dr. Johnson outlined the role of Native Authorities in providing medical and health services in Nigeria which included the building of Native Authority hospitals, dispensaries, child welfare centres, and the training of African subordinate staff.[64] An interventionist Indirect Rule was initiated in the Gold Coast in 1936 when the Native Treasury Ordinance was introduced.

Thus the early establishment of Native Authorities in Nigeria facilitated the provision and extension of medical and health services to the rural areas. In the other British West African territories, medical and health facilities were provided primarily by the Central Government and as a result were concentrated in government centres to the neglect of the rural areas. In the Gold Coast, many hospital buildings had been erected by the end of the 1920s in the important towns and at considerable expense; but dispensaries in the rural areas were few and in the Northern Territories almost non-existent. The initiative for their development was left largely to the local native authorities, who, in the absence of a regular native treasury system, had no means of making the necessary provision for them. Such disparity in the provision of medical and health service between the urban and rural areas was one of the most striking features of medical and health policy in British West Africa in the inter-war period.

AFRICAN JUNIOR PERSONNEL

Colonial governments in British West Africa were generally agreed that if medical and health facilities were to be expanded for the good of the general population, there had to be a substantial increase in the number of trained Africans who would be employed in subordinate medical posts. Lack of qualified personnel was one of the greatest difficulties which faced these governments in their endeavours to bring the benefit of medical science and skill within the reach of the African peoples. It was obvious that the deficiency could never be made good by any expansion in the number of European doctors employed in government service, even if these were available in large numbers, which they were not.[65] Thus the only source from which it could be met was the African population itself.

The Nigerian Government was the first to take the initiative. In 1924, the subordinate medical staff was reorganized with better pay and prospects, and the standard of training and efficiency was raised.[66] It was also hoped that the number of African nurses would gradually be increased from a total of 198 to 297. The increase of staff was necessary to provide adequate attention as the hospitals became more popular. The Principal hospitals were thus enabled to train nurses, as well as laboratory attendants and midwives.

Nurses sat for their qualifying examinations at the training centres in Lagos, Calabar, Port Harcourt, Warri and Kaduna. In 1927 a Pharmacy School was founded in Lagos: dispensers were trained there and sat for their qualifying examinations after a three-year course.[67] In 1927, with the full support of the Colonial Office, the Nigerian Government inaugurated a scheme for the training of Northern Nigerian indigenes for subordinate medical posts. This involved the selection of boys at the Katsina Training College for training as medical assistants at the Medical School in Zaria.[68] At the same time discussions were also going on on the establishment of a Medical College for the whole of British West Africa.

The need to train more African medical personnel had long been recognised both by Colonial governments in West Africa and by the Colonial Office. In September 1920, the Departmental Committee appointed to enquire into the Colonial Medical Service recommended the establishment of a school of medicine in West Africa.[69] In January 1921 this recommendation was given full support by the professional members of the Advisory Medical and Sanitary Committee for Tropical Africa.

Sir James Fowler drew the attention of the Colonial Secretary to the fact that the French had established a Medical School in Dakar for the same purpose. He referred to the shortages of Medical Officers and said the proposal would help to remedy it.[70]

On August 30, 1921, Winston Churchill, then Secretary of State for the Colonies, sent out a despatch to colonial governments in West Africa on the subject of the Colonial Medical Service and in particular on the question of founding a Medical College as a preliminary to the establishment of an auxil iary medical service. In response, Dr. J. M. O'Brien, Senior Medical Officer in the Gold Coast, visited Dakar and submitted a report on the school of Medicine there, on the lines of which it was suggested that a school of medicine should be established in British West Africa. The formulation of a detailed scheme was, however, at that time considered to be premature as the facilities for general education up to the the required standard were lacking.[71]

A few years later, it was considered that the advance in secondary education throughout the region justified a more thorough investigation into the possibility of a Medical School. In December, 1925, at the third conference of the senior members of the West African Medical Staff (WAMS), the subject was fully considered and a scheme for the training of medical students and medical assistants was outlined. The conference considered that the ultimate aim should be to provide a degree course, but that the immediate need would be met if the training at the college was at first limited to turning out medical assistants.[72]

There were several reactions to this recommendation from the colonial governments concerned. In February 1926, Sir Gordon Guggisberg, Governor of the Gold Coast, wrote a long despatch to the Colonial Office stating that he had pledged his Government not to introduce any scheme for training medical assistants without at the same time providing a degree course for Africans. He suggested that until the proposed college could be developed to provide a complete course, a system of sending the most promising 'medical assistants' students to Britain with scholarships to take a degree course should be introduced. He advocated the appointment of a committee to consider the whole matter.[73]

Similarly, in June 1926, Sir Graeme Thompson, Governor of Nigeria, wrote expressing agreement with the proposal that a college should be established. At the same time he expressed the view that Nigeria would not be able for a long time to provide more than very few, if any students and proposed to concentrate at first on producing medical assistants.[74] Both Graeme Thomson and Ransford Slater of Sierra Leone also agreed to the appointment of a committee.

In May 1927, L. S. Amery, the Colonial Secretary, took advantage of the presence in Britain of Sir G Guggisberg, Sir G. Thomson, Dr. D. Alexander and Dr. W. J. D. Inness (DMSS, Gold Coast) to discuss with them the proposal. It was agreed that a committee should be appointed in West Africa to consider the matter. In communicating this decision to the West African governments, the Colonial Secretary committed himself to the principle of a medical

college in West Africa but expressed the view that the training of medical assistants should not be centralised in one institution but taken up in each territory independently.[75]

A committee was appointed by the Colonial Office and was composed as follows: W. J. D. Inness (Gold Coast DMS in the Chair), D. Alexander, T. B. Adam (DDMSS, Nigeria), J. C. S. Mcdonall (DMSS, Sierra Leone); G. H. Macalister (principal, Medical College Singapore) and A. G. Fraser (principal, Achimota College). The terms of reference were:

> To draw up a scheme for establishing in the Gold Coast, a Medical School whose diploma will be admitted to recognition in the four British Colonies in West Africa; to advise as to the standard of education required of entrants to the school; to prepare conditions under which partial training will be recognised as qualifying students for appointments as medical assistants; to make recommendations regarding the staff required and their salaries and the buildings which will be needed; and to submit estimates of the capital cost and annual expenditure required to give effect to their proposals.[76]

The committee met in Accra in 1927 and reported the following year. They recommended that steps should be taken forthwith to set up a medical school which would provide a full course and turn out doctors qualified to practice in West Africa. The committee also recommended that the training of medical assistants should be diverted entirely from the Medical School if approved and be proceeded with separately.[77]

There was little doubt about the desirability of a Medical College in West Africa; the question was whether the time had come in 1928 to proceed with so far-reaching and costly a proposal. The committee pointed out that some 30 Africans passed the Cambridge senior local examinations each year and that this number was expected to increase. Besides the necessary buildings for the Medical School could not be completed under three years, so that even if building operations were begun at once, no students could be admitted before 1931 at the earliest. The committee thus concluded that the prospects justified an immediate start.

The Governors of Nigeria and Sierra Leone were of the opinion that at any rate for a considerable time to come the number of students from those colonies capable and desirous of entering the medical profession in any given year would be so small as to be practically negligible. Understandably these Governors hesitated to commit their governments to a scheme involving heavy expenditure for which they could see no prospect of obtaining any appreciable return for years to come. These Governors favoured a scheme for the training of medical assistants in individual territories.[78] In the Gold Coast, prospects were undoubtedly more favourable, but the Gold Coast could not finance the College unassisted by contributions from other West African colonies. After reviewing the matter in all its aspects Sir J. Byrne, Governor of Sierra Leone, said that the whole idea of a college was premature, though it might be worthy of consideration in four or five years time.[79]

In the light of these comments, the Colonial Secretary, L. S. Amery, decided to postpone the project, but he expressed the view that he would be prepared to review the matter before the end of the five-year period if evidence was forthcoming that African students were finding it impossible to obtain medical education in the U.K. Meanwhile, he saw no objection to scholarships being granted by the various governments to promising students who might wish to study medicine in the U.K. He further approved plans for the training of medical assistants in accordance with the recommendations made by the committee.[80]

In the Gold Coast the Government decided to drop the native medical assistant scheme and to substitute an approved dispensary service throughout the territory. Apparently the Government was pledged not to institute anything in the way of medical training that would not lead up to the students obtaining a full medical degree. As a result, in 1929 the Government instituted medical scholarships for Gold Coast Africans who wished to study medicine overseas.[81] In the following year a scheme for training African dispensers to take charge of village dispensaries was also inaugurated.[82] This was necessary because it was generally agreed that there was a real need for an improved and extended dispensary service.

In Nigeria however, the first class of African medical assistants commenced instruction at Yaba College, Lagos, established in 1930.[83] Upto the period immediately after WWII, the Yaba Medical School was the only centre of medical

education in the British West African Territories. The aim was to provide medical assistants for the government medical services rather than attempt to give training up to the professional standards recognised in Britain.

By the end of the 1920s much had been achieved in the area of curative medicine. This progress was largely due to the establishment of a number of medical institutions by the Colonial Governments, the Native Administrations and some missionary organizations. Much had also been achieved by way of improving the health of European residents in the region by the provision of basic sanitary facilities in the urban areas. The various Colonial governments, aware of the enormous task ahead of them, came to the conclusion that no satisfactory progress would be made unless the work was taken up by the native Administrations and Town Councils. Thus by the early 1930s, the responsibility for providing medical and health facilities in the rural areas had been handed over to Town Councils, Sanitary Boards or Native Authorities as the case might be. The role of central governments was confined primarily to providing plans, financial aid, advice and supervision. It was at this point that the world economic slump set in.

THE IMPACT OF THE DEPRESSION

The 1930s were dominated by the international economic depression. Its effects on colonial governments were severe. New projects were abandoned, staff were not

appointed to fill vacant posts, and hospital maintenance costs were cut. Training schemes were not developed at the rate expected and plans for the up-grading of staff in rural areas were not fulfilled. There were cuts in personnel as well as financial cuts.

In the Gold Coast the economic depression affected adversely the health of both African and Europeans, yet between 1931 and 1932 the number of cases treated fell by 7.25 per cent. This was due largely to the heavy reduction in the number of medical officers: they were withdrawn from five stations, and some places including Saltpond, were deprived of them for varying periods.[84]

Similarly, in 1931, there was a large reduction in the medical expenditure of the Nigerian Government;[85] and in 1932, Sir Donald Cameron (Governor), instructed W. B. Johnson (DMS), to put forward a scheme for reducing expenditure by another 15 per cent through laying off clinical staff.[86] The scheme drawn up by Johnson in 1933 involved the retrenchment of 23 European medical officers, 2 lady medical officers, 2 dentists, 1 pharmacist, 1 matron, 1 senior nursing sister, 4 health officers, 3 pathologists, 1 technical assistant and 8 vacancies for medical officers were to remain unfilled.[87] In the same year the following medical stations were closed down: Zuru (June), Obubra(August), Buea in British Cameroons (December).[88] Prospects looked bleak indeed. On the one hand, it was

obviously impossible to maintain a large hospital system when expenditure depended from year to year upon the varying revenue of the country. On the other hand, the finances of the Nigerian Government at the depth of the depression were such that the Government could not meet from its revenue the free medical treatment which more and more people were coming to take for granted.[89]

As a result, Johnson was convinced that the activities of the Central Government Medical Department should be strictly confined to prevention of disease, improvement of hygiene amongst the people and education of Africans to enable them to take over the medical and sanitary work of their country.[90]

"No great service is done to the health of Nigeria by nursing an individual patient through an attack of pneumonia or by operating upon him for a hernia"[91], he added. He therefore proposed that the Nigerian Government should gradually hand over to local administrations, free of cost, all government Hospitals and their equipment, with the exception of the European Hospitals and a few large African base hospitals where specialist advice and treatment could be obtained, where African doctors trained in Nigeria could gain experience and where African nurses could be efficiently trained for service in non-government hospitals.

Although government hospitals were not handed over to local Administrations, the 1930s in Nigeria were dominated by the expansion of the dispensary system through which

epidemic diseases such as smallpox and yaws were treated; the training of African staff; and the expansion of maternity and child welfare services. These developments were largely made possible by the Colonial Development Act of 1929. This authorised the expenditure upto £1 million annually on Colonial projects which might include the promotion of public health and scientific research.[92] In March 1930, the then colonial secretary, Lord Passfield, appointed the Colonial Development Public Health Committee (CDPHC), a temporary committee with the following terms of reference:

> To consider what recommendations should be made to the CDAC for the use of a portion of the CDF for the promotion of public health in the Colonial Empire; and to advise under what conditions grants made available from the fund can best be administered.[93]

The Committee was made up of prominent people with vested interests in public health such as Dr. T. Drummond Shiels (Chairman), Sir Andrew Balfour, Sir Basil Blackett, Dr. Mary Blacklock, S. P. James and Dr. A. T. Stanton. This committee observed,

> that the health of the people is a primary factor in the economic development of a territory is not open to question. Indifferent health, whether from disease or malnutrition reduces the capacity for work. This depresses the standard of living of the inhabitants and prevents the proper development of the resources of the Territory and the expansion of Government revenue on which depends improvement in the standard of administration and measures for improving the material and moral well-being of the people. The value of other forms of expenditure, e.g. on education, is largely dependent on the standard of health.[94]

Furthermore, the Committee were of opinion that a reasonable standard of health in the Colonial Empire could only be achieved through the active participation of Africans in the work of the medical services. They therefore recommended that assistance from the fund should be given for the training of local men and women as dressers, nurses, health visitors and midwives. For auxiliary medical services, assistance might be given from the Fund towards the initial capital outlay for buildings, training schools and hostels and, where necessary, towards maintenance for a limited period. Thus the Committee called on colonial governments to make use of the resources made available to embark with fresh enthusiasm on the extension of their health and sanitary services.

It has been argued that colonial governments hardly derived any benefit from the CDF; the reasons being that assistance was given on a purely ad hoc basis and secondly that apart from grants - in - aid and emergency relief, Imperial assistance was confined principally to the guaranteeing of Colonial loans and to enabling colonial governments to raise funds on the London market at preferential rates of interest.[95] This might have been true with regard to such large capital projects as the construction of railways and the development of the Marampa iron ore concession in Sierra Leone. However, by early 1930, the CDAC began to show signs of concern when no new projects for assistance were sent to them by colonial governments. In February 1930, Sir Basil Blackett, Chairman

of the CDPHC, told the Colonial Office that if sufficiently ambitious schemes were to be encouraged, then organized effort from the metropolitan end was necessary.[96] As a result, Sir Samuel Wilson, the permanent under-secretary, on behalf of Lord Passfield addressed a letter in March to colonial governors, explaining the scope of the fund. He further explained that the attitude of the Advisory Committee towards applications was not governed by a narrow view of the unemployment problem in Britain. Thus the Committee was ready to entertain applications which involved

> little actual purchase of material in this country, or even none, if the object to which it is proposed to devote the money, is one which may be expected to promote the development of the Colony, and thus indirectly to add to its wealth and consequently purchasing power, to the general benefit of the trade of the Empire.[97]

Wilson's letter and the publication of the Report of the CDPHC in July 1930, contributed in redirecting the priorities of colonial governments, especially those in West Africa, on colonial development. In the course of the 1930s transport and communication schemes tended to become relatively less important and public health ones including anti-erosion schemes and water supplies relatively more important.[98]

The CDAC took the view that wise expenditure on public health was essential to economic development. Thus they did not hesitate to give sympathetic consideration to a number of applications designed to improve public health in the colonies.[99]

The Nigerian government was determined to extend medical and health services to the bulk of the population by involving the indigenes themselves. In 1930 therefore they, requested assistance from the CDF for the following projects: the erection of maternity training centres, a training centre for African sanitary inspectors, Native Administration Dispensary schemes, the provision of motor ambulances, establishment of a leper colony, sanitary improvement schemes and a Labourers housing scheme.[100] In September 1930, the CDAC recommended free grants totalling £55,000 towards the cost of these public health schemes. The recommendation was made (and subsequently approved by the Treasury), on condition that the Government of Nigeria undertook to meet the remaining expenditure from its own resources. The Committee also approved a loan of £10,000 at 5 per cent, repayable in ten years, for the labourers' housing scheme in Port Harcourt.[101] Due to the financial depression, the Nigerian Government requested that the number of motor ambulances included in the original proposals be reduced, thereby lessening the contribution from local resources to the whole programme from £18,600 to £10,000 (the original cost of the public health schemes was £65,200).[102] In February 1931, the Committee acceded to the request and in spite of the financial situation the Government was able to proceed with the schemes.

The need for training African midwives and health visitors cannot be over-emphasised. The infant mortality rate for Lagos, where hospitals and medical assistants,

including a Maternity Hospital were available still stood at the high figure of 134 per 1000 in 1930.[103] Although in the country generally no birth or death registration was enforced, very high infant mortality was evident wherever welfare centres were established. It was however, obviously impossible to reach a population of over 19,000,000 with welfare centres staffed by European female medical officers and nursing sisters; they could only touch a fringe of the work. Trained midwives were also needed to be attached to dispensaries established throughout the country under the auspices of Native Administrations.

In 1930, there were only two training centres for midwives in Nigeria, at Lagos and at Abeokuta. It was proposed that two more centres should be started in the Southern Provinces, at Calabar and Aba, and one at Ilorin for the Northern Provinces. The centre at Ilorin was opened in April 1934 and the one at Aba early in 1935. The Aba centre was an immediate success. It formed a maternity hospital base for a travelling female Medical Officer. At Calabar the centre was at first opened as a welfare centre.[104]

The Native Administrations in Nigeria had shown much enterprise in engaging African sanitary inspectors, but the numbers which it was possible to train under the existing facilities were totally inadequate to meet the demand. There was only one school in Lagos where training by a three-year course was undertaken. This school alone could

not cope with the number of sanitary inspectors required. A start was made at Kano in 1930 for the Northern Provinces, but the buildings were inadequate. In applying for assistance, Johnson proposed that the school at Kano be improved and enlarged to enable boys to be trained for both Government and Native Administration Service and that training schools for Native Administration sanitary inspectors be started at Aba and at Ibadan in the Southern Provinces.[105]

The training centre for African sanitary inspectors at Ibadan in Oyo Province was opened in April 1933; it was maintained entirely for the training of future Native Administration employees. A two-year course was given and 25 pupils were selected for training in the first year. These students were of great assistance during a serious epidemic of smallpox in the Province in 1934; the Training Centre was temporarily closed down and the students employed to perform vaccinations. During February, 26,423 vaccinations were performed in Ibadan; 106 for Europeans 21,813 for others and 4,515 routine vaccinations by Native Authority Staff.[106] The school at Kano was opened in December 1933. Twenty-one pupils were admitted in the first year and instruction was given in the Hausa language. The third school at Umudike in Owerri Province was opened towards the end of 1934 with eleven pupils.[107] B. H. Bourdillon who had taken over from Cameron in 1935 as Governor of Nigeria remarked in 1935 that

> the proper training of Sanitary Inspectors employed by Native Administrations is having a markedly beneficial effect and has done much to enlist the sympathy and support of native rulers for sanitary improvements as they are themselves paying the bill.[108]

The Native Administration Dispensary Scheme in Nigeria was commenced in 1929 after consultation with the Lt. Governors and Residents. It consisted in planning each year a number of new dispensaries for each province, the plans being made one year ahead in order to enable buildings to be erected and equipped and the staff to be trained. The scheme aimed at bringing the service of European medicine to the bulk of the population, treating extensively venereal diseases, yaws and helminthic diseases, and the early recognition of epidemic diseases. However, many Native Administrations, although keen to adopt the scheme, had insufficient resources to allow them to do so. Thus it was to the interest of the Central Government to assist such Native Administrations by grants towards buildings and equipment. The Nigerian Government received a free grant of £12,000 from the CDF for this purpose.[109]

By 1935, 263 Native Administration Dispensaries had been opened in Nigeria. The grant from the CDF enabled the poorer Native Administrations (N.A.) to proceed with the scheme, until then only possible for wealthier bodies. Indeed, during 1934, 628,065 patients received treatment at these dispensaries.[110] In Cameroon Province the grant was used to equip numerous village centres with apparatus

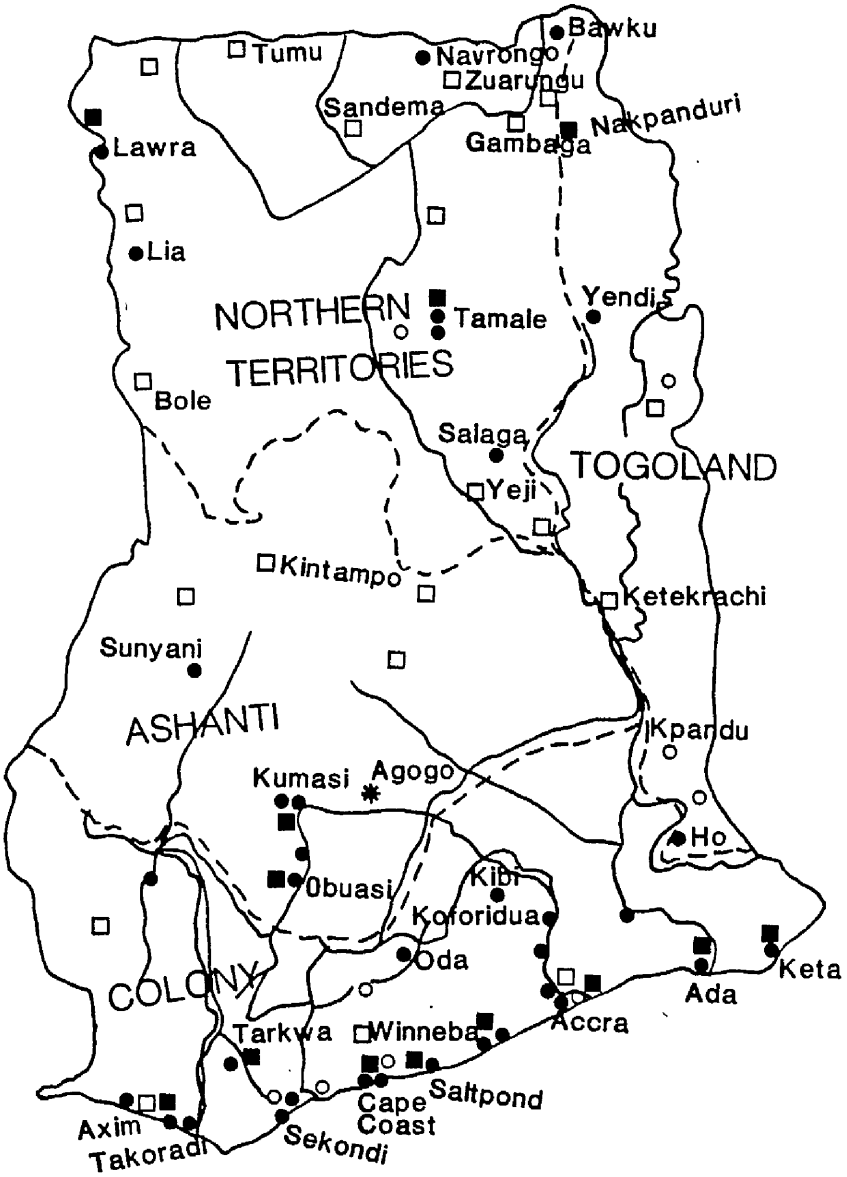
and drugs for treating yaws instead of building two permanent dispensaries. In 1934, 96 trained men were at work and 58,000 injections of a bismuth preparation were given.[111]

To increase the scope of the African hospitals, the Nigerian Government requested assistance for the provision of motor ambulances. These would ease evacuation of cases for treatment to the nearest centre. In 1930, there were ambulances at 33 centres: 14 in the Northern Provinces, 15 in the Southern Provinces and 4 in the Cameroons. By 1935, ten motor ambulances had been purchased under the grant to supplement those already in existence so that every dispensary on a motorable road could evacuate cases of serious illness to a base hospital.

A free grant of £6,000 was asked for the establishment of a Leper Colony in Benin Province. In the Southern Provinces there was a large leper colony at Itu in Calabar Province, with accommodation for 2,000 lepers. This was run by the Church Missionary Society with support since 1928 from the Government and the British Empire Leprosy Relief Association.[112] There was also the Uzuakoli Colony in Owerri Province under a European missionary doctor but maintained by the Native Authorities of Owerri, Ogoja and Warri.[113] An additional colony was, however, required for Benin Province as the Southern Region of the country was regarded as the most heavily infected area in West Africa. The Centre was opened in July, 1933 with 187 male and 51 female lepers in residence under a Lady doctor and two assistants.[114]

MAP 4

Gold Coast Medical Facilities, 1935



0 10 20 30 40 50

Miles

KEY

✱ Basel mission hospital
● Hospital
■ Contagious disease hospital
○ Child welfare centre
□ Dispensary

As regards sanitation in general, provision under the grant was made for propaganda intended to improve sanitation. With assistance from the CDF, W. Sellers (Sanitary Superintendent, Lagos) put forward a scheme for the establishment of a Health Propaganda Unit in April 1935.[115] The Unit was established in 1936 with Sellers in charge. The duties of the Unit included making films suitable for health propaganda with African audiences; spreading health propaganda among the general public and stimulating the interest of N. A. in Sanitary improvements in towns; giving lectures and practical demonstrations to educational, medical and health officers on school and domestic sanitation, using local materials; establishing of committees known as Rural Health Units and organizing those activities which they could undertake;[116] and making and supplying models of sanitary structures, posters, and leaflets. Through the ingenuity of Sellers, a number of films of great value to public health work in Nigeria were produced.[117]

On the whole, the progress made in improving public health in Nigeria with assistance from the CDF was quite impressive. The Gold Coast Government, on the other hand, was concerned to improve its infra-structures rather than public health. Thus the provision of water supply at Tamale and electric light at Cape Coast were the only public health improvements schemes for which assistance was asked. For water supply at Tamale, a direct grant of £20,000, and a

MAP 5

Sierra Leone Medical Facilities, 1935

Reference

- ● European hospital
- O African hospital
- \+ Mission hospital
- □ Mines
- ★ Infectious diseases
- ▲ Dispensary

loan of £20,000 was requested from the CDF, the loan to be repaid in five annual instalments.[118] However, the CDAC recommended that the whole cost of the scheme (£40,000) should be met by a loan from the Fund to be repaid within ten years, the first three years free of interest and thereafter at 5 per cent.[119]

The major public health scheme presented by the Government of Sierra Leone was the canalisation of streams and the improvement of street drainage in Freetown. The scheme comprised the canalisation of Saunders Brook from the city boundary to its outlet in Kroo Bay and the completion of the street drainage which discharged into Saunders Brook.[120] The scheme was primarily a localised anti-malaria measure. Its estimated cost was £60,500, of which the CDAC approved a free grant of £26,000. Although it was impossible to give definite figures proving that canalisation could lessen the number of mosquitoes, experiments conducted in 1930-31 by Professor Gordon of the Sir Alfred Jones Research Laboratory demonstrated that drainage had a definite effect in lessening the number of mosquitoes: in 1931, the ratio of mosquitoes in the non-drained area was 2.74 per house and in the drained area 0.55.[121]

In the Gambia, Governor Palmer, after reviewing the conditions prevailing in the Colony and its position in relation to the Protectorate, drew the attention of the Colonial Office in 1930 to the urgent need to improve the Bathurst water supply. He requested a free grant of

£100,000 to meet the cost of water works, a tram line from Bathurst to Kombo, a Wharf and irrigation.[122] The request was turned down but the need for this public health improvement scheme was further highlighted with the outbreak of yellow fever in Bathurst in 1934 involving the death of four Europeans including the Colonial Secretary.[123] As a result the Government drew up fresh plans which included a drainage and reclamation scheme, a new African Hospital, the improvement of water supply and extension of electric lighting. Proposals for these schemes were submitted to the CDAC in 1935, involving a free grant totalling £250,000.[124] They were approved by the committee. The Committee were satisfied as to the development value of the two schemes and in recommending them, took into account the fact that the Government of the Gambia would have to raise loans to meet the large expenditure in connection with the general improvement of Bathurst.[125] However, as a result of the financial situation of the Gambian Government, the scheme for the general improvement of Bathurst was postponed until after the war.

It could be rightly said that the Nigerian Government made considerable use of the CDF in providing public health facilities for the general population. In Nigeria, therefore, much more than in the other British West African Territories, there was, by the end of the 1930, considerable development of government medical services, a new policy orientated towards emphasising African interest, expansion of the staff of the Medical department,

particularly the number of trained African employees and a great amount of work accomplished in both curative and preventive medicine. Meanwhile, however, the Colonial Office and Colonial Governments were not only making efforts to provide medical and health facilities; efforts were being made to encourage medical research. The organization of medical research in British West Africa between the wars is the subject of the next chapter.

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CHAPTER TWO

THE COLONIAL OFFICE AND MEDICAL RESEARCH IN BRITISH WEST AFRICA, 1919-1939

INTRODUCTION - RECOGNITION OF THE PROBLEM

Awareness of the need for research into tropical diseases dates back to the beginning of the twentieth century, when the Colonial Office expressed a desire to link scientific research more closely with medical training. Just as tropical diseases made it necessary to establish institutions in Britain for the training of medical men in the treatment and prevention of these diseases, so did they stir up a sense of need for research into their causes, prevention and cure. The initiative came from the Colonial Office, under the Secretaryship of Joseph Chamberlain. In 1903, Chamberlain addressed a circular despatch to colonial governments in which he summed up the steps which had been taken to investigate malaria and to train medical officers in the prevention and treatment of tropical diseases. He emphasised that the work should be carried further and suggested that colonial contributions should be paid into a common fund out of which the objects referred in the despatch might be subsidised. These objects were the scientific investigation of diseases prevalent in the tropics and the training of medical officers for service in tropical colonies. He added that should his proposal be entertained, he would propose to

> appoint a committee to advise the Secretary of State as to how the moneys received can at any given time be best allotted, such a committee to consist of the medical adviser to the Colonial Office; a representative of the Royal Society; some leading London Physicians and one or more representatives of the crown colonies.[1]

The result of this appeal was that a sum of about £2,700 a year became available, contributed by colonial governments (£1,500), the imperial government (£500), the Government of India (£500) and the Rhodes Trustees (£200).[2] An Advisory Committee for the Tropical Disease Fund (ACTDF) was set up in 1904, under the chairmanship of Sir J. West Ridgeway, From its inception, grants were made mainly to the following institutions: to the Liverpool School of Tropical Medicine, to the London School (£500) and for general purpose of research to be expended on the advice of the Royal Society; the University of London for a chair of Protozoology and the University of Cambridge (for the Quick Biological Laboratory) on the application of Professor G. H. Nuttall. [3]

When the Advisory Committee was formed it was intended that it should advise on all matters connected with medical research in the tropical colonies. In its earlier days the committee professed to exercise, with the approval of the C.O., some form of control over the work of medical research organizations then being established in the colonies and financed by colonial governments. At that time, annual reports and special reports were sent to the committee from tropical laboratories. This control gradually weakened during the first world war and by the early 1920s had disappeared altogether. With the establishment of the

Colonial Advisory Medical and Sanitary Committee in 1922, these reports were appended to the Annual Medical Reports and were considered by the new body. As a result, the functions of the Advisory Committee of the TDRF was restricted to approving stereotyped grants from a fund that gradually diminished to some £2,000 a year, and receiving annual reports of bodies to which grants were made.[4] The grants were, more often than not, devoted to the general purposes of these institutions and no separate accounts were kept to show how the money was expended.

Generally speaking, the 1920s saw an emerging interest on the part of the imperial government in scientific research into the problems of the colonial empire. The main emphasis was on the application of science to the development of the resources of the colonial territories.[5] In 1919, Lord Milner, then Colonial Secretary, instituted the Colonial Research Committee under the Chairmanship of Sir Halford Mackinder. The main areas of interest were mineral resources, agriculture, animal health, forestry and fisheries. Medical questions were considered to be outside the committee's preview. Medical investigations were not to be undertaken unless they had direct economic relevance. Again in 1920, Lord Milner appointed a committee to consider and report on what steps could be taken to secure the assistance of British universities in carrying out research work which was essential to the improvement of agriculture and mineral resources and the protection of colonial peoples from diseases.[6] In their report, the committee suggested that the Universities could assist in the training of

students from whom could be drawn recruits for colonial scientific departments and in the building of a corps of scientific workers whose services could be utilised whenever needed. However, the report did not create the hoped for publicity nor did it produce any concrete results. Unfortunately, the letter which was addressed to universities and allied institutions in the U.K. was not addressed to any of the medical schools. According to H. J. Read, "as regards tropical medicine and sanitation, several organizations can be named which give the requisite assistance and advice".[7] In effect, this meant that medical questions were not to be considered.

The complacency within the Colonial Office as regards medical research in the colonies stemmed basically from the fact that the interest of the imperial government in the 1920s was primarily in research which was of practical economic importance. On the other hand, the tendency had always been that the C.O. would respond immediately to any calamitous outbreak of an epidemic disease (as it did in the early years of this century to malaria and sleeping sickness), but once the immediate catastrophe was past, would relapse into the old indifference to medical research. Thus medical research became ad hoc and based on expediency.

Although credit for the development of scientific research on all fronts has often been given to L. S. Amery, who was Colonial Secretary from 1924 to 1929, and to his parliamentary under-Secretary, W. Ormsby-Gore (later Lord

Harlech);[8] their public utterances went a long way to prove that they had not departed from the school which emphasised research to promote economic development'. In the Times of January 30, 1924, L. S. Amery wrote that, the development of the Empire was not only a great political and administrative problem, it was also, he insisted,

> a great scientific problem - a problem of applying scientific research to the practical task of making the most of our immense resources.[9]

Of course, what was implied was the development of agricultural, forestry and mineral resources.

Addressing a League of Nations conference on sleeping sickness in Africa in May 1925, Ormsby-Gore maintained that

> we cannot henceforth isolate altogether the problem of Sleeping Sickness from the problems of animal trypanosomiasis. From the economic, social and administrative points of view, nagana (cattle Trypanosomiasis) is as important as, if not more important than Sleeping Sickness.[10]

Similarly, on his tour of the British West African Territories in 1926, Ormsby-Gore was pre-occupied with agriculture and communications. Although he made impressive observations on medical and sanitary questions, it was clear that this subject was low in his list of priorities.[11] Commenting on this tour, the Nature editorial of October 30, 1926, observed that,

> the need for further research in tropical diseases and the measures to be taken to secure a health and increasing population are emphasised, but not over-emphasised.[12]

Thus the emphasis in the 1920s and indeed until WWII was for the imperial government to encourage the improvement and increase of the sources of raw materials needed for British industry.[13] However, it was while Amery and Ormsby-Gore were in office that practical efforts were made to promote research on all fronts.

The separation of the Colonial Office from the Dominions Office in 1925 made possible the necessary organizational basis for directing attention to the study of specific problems of the colonial empire. The impetus to organise research on all fronts was given at the Imperial Conference of 1926. In pursuit of a decision taken at the opening meeting of the Imperial Conference, a Research Sub-committee was set up with Lord Balfour in the chair. Out of the report of this Sub-committee the conference recommended the active prosecution of research in all fields of applied science; with the fullest practicable cooperation between the organizations in Britain respectively responsible for agriculture, fisheries, forestry, medicine and industrial research.[14]

Meanwhile, in 1926, the post of Chief Medical Adviser was created in the Colonial Office and one of the responsibilities of the post was the encouragement of medical research in the colonies. By 1927, no action had been taken on the resolutions of the imperial conference

concerning research. As a result, A. T. Stanton, Chief Medical Adviser, remarked that,

> whatever may be the outcome of the resolutions of the Imperial conference of 1926 on the subject of research, there will remain a place for a C.O. organization dealing with problems of medical research in the tropics.[15]

It is true that the CAMSC did act as a consultative body to the colonies on medical and sanitary matters and that it gave advice when asked for it. But it had become increasingly clear that what was needed was an authoritative body which would be in a position to formulate policy and programmes of research without waiting necessarily for stimulus from outside. The need for such an organization was recognized equally by the C.O. and the Medical Research Council and was given its blessing by the Colonial Office conference of 1927. It was to be called the Colonial Medical Research Committee. Whether this body fulfilled the above aspirations is a different matter.

THE COLONIAL MEDICAL RESEARCH COMMITTEE

At a meeting of the Advisory Committee for the Tropical Disease Research fund, held on December 2, 1926, the future position of the committee in relation to research was discussed. Sir Walter Fletcher, Secretary of the MRC, pointed out that the work done by the committee was far too limited in scope and that its constitution required drastic revision.[16] As stated earlier, when the committee was formed in 1904, it was intended that it should advise on all

matters connected with medical research in the tropical colonies. By 1922 however, much of the work done by the committee was taken over by the CAMSC so it came about that the Advisory Committee for the TDRF had nothing to do with research beyond the allocation of grants and receiving the annual reports of bodies to which grants were made. With the general reorganization that took place in the C.O. between 1925 and 1928, it became necessary to restore the committee to something of its former usefulness.[17]

Apart from the need felt by research workers in the tropics for more effective contact with research workers in Britain, it was becoming clear that research in the tropics could have an important bearing upon the disease problems of temperate zones. For this reason the MRC expressed the desire to extend its work to the tropics. The matter was discussed between Sir Walter Fletcher and A. T. Stanton, Chief Medical Adviser at the Colonial Office. As a result of these discussions, the C.O. and the MRC agreed on a plan of cooperation.[18]

In April, 1927, A. T. Stanton put forward proposals for the reconstitution of the Advisory Committee of the TDRF.[19] Dr. Stanton's proposals were laid before the C.O. conference held between 10 and 31 May, 1927.[20] The conference recommended and endorsed the appointment of a joint committee of the C.O. and the MRC to deal with medical research in the Colonial territories. The new committee was to replace the Advisory Committee for the TDRF. The C.O. conference further recommended that the new committee

should consider: a scheme for the establishment of a Colonial Medical Research Service based on contributions to a common pool; and the payment from a pool of grants to medical institutions including hospitals which were considered to deserve the support of Colonial governments.[21]

The MRC were accordingly informed of the proposals.[22] The Council welcomed them and gave their approval.[23] As a result of this cooperation, the Colonial Secretary in consultation with the MRC appointed the Colonial Medical Research Committee (CMRC) under the chairmanship of W. Ormsby-Gore, then the Parliamentary Under-Secretary of State. The committee had the following terms of reference:

> to advise the Secretary of State and the MRC upon the initiation and promotion of medical research in the interest of the Colonial Empire; upon the recruitment and conditions of service of the necessary personnel, and upon the management and allocation of any funds available for these purposes.[24]

The members of the committee were nominated jointly by the Colonial Secretary and the Lord President of the MRC. Dr. William Fletcher (formerly Director of the Institute for Medical Research, Federated Malay States), was appointed the medical secretary. His salary of £1000 per annum was shared equally between the MRC funds and the TDRF. Although the Advisory Committee of the TDRF was reconstituted, the funds of this body were not dissolved. The newly appointed CMRC had no funds of its own but its expenses were charged to the Tropical Disease fund (TDF) account.[25] The duty of considering reports from research institutions and other

laboratories was withdrawn from the CAMSC and assigned to the CMRC.

It was the desire of the C.O. that research workers in the colonies should take full advantage of the services provided by the new committee. In a circular letter to colonial governments in February, 1928, L. S. Amery stressed that officers engaged in research or in the investigation of any particular problem should take the opportunity of calling upon the medical secretary at the C.O. when they were on leave in the U.K.[26]

THE WORK OF THE COMMITTEE

It was clear from the beginning that it would not be practicable for the committee to attempt to define any plan of work until they knew about the research programmes being undertaken in the Colonial territories. Thus, at their first meeting, the CMRC decided that a survey of the research work then in progress in the various Colonial territories should be undertaken. The survey was conducted by Dr. William Fletcher, the medical secretary to the committee, mainly by interviewing officers when on leave in Britain.[27]

The survey hardly revealed anything new. It comprised mainly a description of the prevalent diseases in the tropics and a detailed discussion of those which at the time were appearing in epidemic form, e.g. plague in Nigeria and yellow fever in the Gold Coast. Indeed, as the survey

revealed, much of the actual research on tropical diseases was being done in areas outside the Colonial Empire: India, South Africa and Brazil for example.[28] As far as British West Africa was concerned, the only organized research work was that conducted by the Rockefeller Yellow Fever Commission based at Yaba in Nigeria and the Sleeping Sickness Research Unit, also in Nigeria. For these territories therefore, what passed for medical research was the routine clinical work done in the laboratories attached to the bigger hospitals.

After the survey however, the CMRC decided, at their meeting of January 23, 1929, to appoint sub-committees to deal with the following subjects:

1. Blackwater Fever (under Manson-Bahr and William Fletcher).

2. Trypanosomiasis Rhodesiense and t. Gambiense and their possible inter-relations or identity (under Dr. Wenyon and W. Fletcher).

3. The therapy of Plague (under Dr. Balfour)

4. Malaria in Barbados (under A. T. Stanton).[29]

The sub-committees, in each meeting of the CMRC, presented reports on the progress of their investigations.

The sub-committee appointed to investigate the question of blackwater fever presented a scheme which involved going

to the tropical areas where the disease was most prevalent. The committee considered the scheme too elaborate. It was argued that the investigation of the disease could be undertaken in London where cases of blackwater fever usually presented themselves at the Hospital for Tropical Diseases. They further argued that it was much easier to deal with individual cases than with large numbers.[30] For these reasons, the committee saw fit to rely on a few cases which occurred at the Hospital for Tropical Diseases in which investigations could be performed under what they called the "best conditions for obtaining accurate results".[31] The true position of course was that members of the committee were committed to concentrating medical research in London, a position which was no doubt influenced by the MRC.[32] On the other hand , medical practitioners in the colonies did not have the time nor the facilities to carry out these investigations which usually entailed the use of special apparatus and technical skill.

The Wenyon and Fletcher sub-committee recommended the setting up an organization comprising an epidemiologist, a protozoologist and a general worker. These would be sent to work in a Rhodesiense area. It was decided that Tanganyika would be the most suitable territory on account of the recent outbreak of the human disease in the area.[33] One of the problems which confronted the sub-committee was that of obtaining the necessary technical manpower.

Dr. Balfour presented a written account of the treatment

of plague by means of anti-serum to the committee during their meeting of February 27, 1929. The medical secretary was directed to enquire from the Lister Institute whether satisfactory anti-plague serum were prepared by them, how long it would keep, and, if serum were required, whether the institute would be willing to supply it to the colonies. Dr. W. Fletcher approached Sir Charles Martin, then Director of the Lister Institute, and discussed with him the subject of serum in the treatment of plague.[34] Sir Charles did not speak highly of the method because at the time anti-plague sera had not been standardised. He added that until some method was devised by which a standardised product could be obtained, treatment by this means could not be placed on a sound scientific basis. The need to investigate the therapy of plague cannot be over-emphasised. Its wide distribution in the tropics, its high mortality and the fact that preventive measures were frequently ineffective in checking its spread all indicated that a serious effort needed to be made to find a more efficacious remedy.

No doubt the CMRC had the desire to initiate and advise on research programmes as evidenced by the formation of special subject committees. Although the diseases chosen for investigation were not new, they reflected the special interests of the members of the committee. In spite of this, however, the committee, right from the beginning, was confronted with a number of problems. First was the problem of obtaining the necessary technical manpower to undertake research work in colonies. Largely as a result of this handicap, the tendency was to concentrate research in

Britain with the result that the application of research lagged far behind actual research work. Secondly, the efforts of the CMRC were hampered by lack of funds. In a CMRC memorandum prepared in January, 1929, it was maintained that

> the present scanty sources of the TDF are insufficient to finance any really effective contribution towards the solution of the many urgent problems connected with tropical diseases.[35]

In the terms of reference of the CMRC, they were instructed to consider the preparation of a scheme for the recruitment and training of medical research workers for work in the colonies.[36] At a meeting of the CMRC held on June 26, 1929, a sub-committee on Finance and Personnel was appointed. The object of this committee was to consider:-

a. a programme of specific problems in medical research and the financial provision required to carry it out.

b. how the requisite personnel might be secured.

c. the position of existing schools of Tropical Medicine in relation to these matters.[37]

In its report, the sub-committee recommended inter alia the establishment of a number of Colonial Medical Fellowships, similar to the Colonial Agricultural Scholarships and the proposed Colonial Veterinary Scholarships. Such Fellowships would be of great value in the training of scientific workers, such as malariologists,

protozoologists and pathologists as well as general workers for temporary or permanent service in the colonies. To provide for these objectives, they recommended a substantial increase in the annual contributions to the TDF. They recommended that the Colonial Secretary should be advised to make an appeal to Colonial governments to increase their annual contributions to the fund.[38]

The Report of the sub-committee was submitted when the Colonial Development Act of 1929 was passed. To meet the above needs, therefore, the C.O. submitted an application to the Colonial Development Advisory Committee (CDAC) for £100,000 spread over five years for the training of specialist workers in the different branches of tropical medicine, the financing of specific schemes of research, visits to colonies by consulting medical experts, and the publication of a journal for the benefit of medical workers in the colonies.

The need for trained personnel in tropical diseases was twofold: for research proper and for the application in the field of the results of the research. It was proposed in the first place to provide training for a number of specialist workers who would be attached to the schools of tropical medicine in London, Liverpool and Edinburgh. Thus teaching staff could be seconded for service in the colonies whenever the necessity arose. Through the Fellowship scheme it was intended that officers already in the colonial medical services would be given the opportunity for specialist training which would increase their professional

efficiency. There was thus an opportunity to establish the basis for a colonial research service. The recruitment of specialist research workers, however, called for the provision of adequate security for their employment.

In the 1930s, in spite of the economic depression, the prospects for advancement for ordinary medical officers in the colonies, particularly members of the West African medical service, were good; but no prospects whatsoever could be held out to research officers. The status and prospects of a medical entomologist in the Colonial Medical Services can best illustrate the situation. An Entomologist who took up the agricultural side of his science had the opportunity of rising eventually to the highest post in his department, provided he proved to have the necessary administrative ability. On the other hand, the entomologist who took up the medical side could never be anything more than a Medical Entomologist, with a maximum salary of £840 or possibly £920 per annum, if such an increase was specifically recommended by the Governor. For this reason, it was difficult to recruit entomologists for the medical departments.[40] Furthermore, some colonies insisted that any entomologist who wanted to join their medical departments must possess a medical degree. In the 1930s, such men were few and these posts remained vacant until the medical departments began to accept men without medical degrees.

Indeed, it was not absolutely necessary for an entomologist of a medical department to acquire a medical

degree, as was pointed out by the Imperial Bureau of Entomology. "It would not appear reasonable," they said,

> to expect a man to undergo the lengthy training necessary to qualify him to practice as a medical man merely in order that he may devote himself to entomological work for which he will have no adequate training.[41]

No doubt, some entomologists, like other scientific specialists without medical degrees, such as protozoologists and bio-chemists, preferred to be attached to medical departments. For this reason, the Imperial Bureau of Entomology suggested to the C.O. that medical research laboratories in the colonies should not be regarded as being part and parcel of the medical profession but rather as scientific institutions attached to that profession.[42] In such circumstances all scientific workers in those Institutions would have equal opportunities for advancement. Thus it was essential to establish a medical research service that would guarantee security for its members.

Meanwhile, the application was discussed by the CDAC. They took the view that while work on tropical medicine was clearly within the scope of the fund, the extent and form of assistance for the purpose should be explored in two respects. First, what was required to be done, in what order of importance and at what cost. Secondly, how the money once granted by the fund was to be administered. For this purpose, some members of the CDAC favoured the idea of a committee to be set up by the Colonial Secretary with wide

terms of reference covering the whole field of public health.[43] Accordingly, Lord Passfield, the Colonial Secretary, appointed the Colonial Development Public Health Committee (CDPHC) in March, 1930 under the chairmanship of Dr. T. Drummond Shiels. The committee had the following terms of reference,

> to consider what recommendations should be made to the Colonial Development Advisory Committee (CDAC) for the use of a portion of the Colonial Development Fund (CDF) for the promotion of public health in the Colonial Empire, and to advise under what conditions grants made available from the fund can best be administered.[44]

Unfortunately, the Colonial Medical Research Committee was not allowed to see the creation of a Colonial Medical Research Service which they had recommended. The committee's functions were terminated in December, 1930. Arising out of the Report of the CDPHC, it was found necessary to look into the organization of medical work in the C.O.[45] By 1930, there were two committees dealing with medical matters in the C.O.: the CAMSC formed in 1922, which dealt with general medical questions and the CMRC, formed in 1927, which dealt with medical research. The division of medical work between the two committees had proved unsatisfactory in practice and from the C.O. point of view was inconvenient. As the chief medical Adviser explained, the arrangement involved,

> a duplication of Secretarial staffs, files and prints but a more important consideration, from the point of view of the Colonial Office, is that it suggested a divorce of medical research from clinical and preventive medicine.[46]

The idea of a committee composed of persons eminent in the field of medical research, which would coordinate the work done in the colonies and supply from time to time programmes of research work, was certainly attractive. In practice, however, it became clear that apart from the reports presented by the special sub-committees at their meetings, the CMRC had not the material available to justify frequent meetings. As time went on, the meetings became infrequent which tended on the one hand to prevent the members from establishing any real touch with work in the colonies, and on the other hand to make it necessary for most matters of practical business to be dealt with by the Chief Medical Adviser without reference to the committee. As a result, the CDPHC recommended that the work of the CMRC should be taken over by the CAMSC. The latter committee would then undergo such changes in organization and personnel as might be necessary.

As the CMRC was jointly appointed by the C.O. and the MRC, the Council was accordingly informed of the intentions of the C.O. to dissolve the committee. The C.O. was, however, careful to point out that the dissolution did not mean an interruption in cooperation between the C.O. and the MRC in the field of medical research. The MRC replied by indicating that effective contact could be maintained by ordinary departmental methods.[47] Thus, after consideration of the report of the CDPHC and subsequent consultation with the MRC, the Colonial Secretary transferred to the CAMSC the duties and functions of the CMRC. This change took effect from January 1, 1931, and the CMRC ceased to exist. In a

meeting of the CAMSC held on February 17, 1931, the committee assumed the title of Colonial Advisory Medical Committee (CAMC).[48] With the dissolution of the CMRC, the idea of establishing a medical research service also died.

Instead of a medical research service, the CDPHC had recommended in their Report that specialists, or groups of specialists, should from time to time be sent out to the colonies at the invitation of Colonial governments to "make suggestions for the preparation and execution of schemes for public health development".[49] The normal reservoir of such specialists was the schools of tropical medicine, but their staffs were not large enough to permit the secondment of one or more officers for duties overseas without seriously interfering with the normal teaching work of the schools. Consequently, the committee recommended the attachment of supernumerary staff in order to make their proposals practicable. Copies of the Report were accordingly sent to the schools of tropical medicine in London, Liverpool and Edinburgh and enquiries were made as to whether they were disposed to assist in giving effect to the recommendations contained in the Report as they affected them. The replies received indicated that all three Institutions were willing to cooperate in the attachment of supernumerary staff.[50] With cooperation from the schools of tropical medicine guaranteed, it was left for the CAMC to discuss and implement the proposals.

Between July, 1930 (when the CDPHC Report was published)

and July, 1931, the CAMC discussed the proposals. They also interviewed a number of colonial medical officers to get their views on the proposals. However, some members of the CAMC rejected the proposals on several grounds. First it was argued that it was impossible for any one to become a specialist in any branch of tropical medicine without long residence in the tropics and that attachment to the schools of tropical medicine in the U.K. would not of itself produce specialists. William T. Prout, for example, pointed out that the right source for the supply of the required staff was the Colonial Medical Service. He further suggested that a sum of about £3,000 a year from the CDF should be spent in the colonies by selecting and attaching supernumerary staff to the health Services, to the laboratories and the hospitals where they would gain some professional experience and be available to be wherever they were required.[51] Other members supporting Sir William maintained that the proposal would not achieve the purpose for which it was designed because the number of tropical diseases in which specialists were required was considerable. They also supported the idea of drawing the required personnel from the Colonial Medical Service.[52]

At their meeting of July 7, 1931, the committee decided to reject the proposals. In the past the need for specialist assistance in the work of colonial medical departments had been met in a variety of ways:

1. by the secondment of officers attached to Institutions

in the U.K., or to Institutions in other countries, for tours of special service in the colonies.

2. by the secondment or transfer of officers from one medical department to another.

3. by the employment of retired officers of the colonial or other service with special experience in the tropics

4. by the despatch of special missions, arrangements for which had been made by the C.O, the Health Section of the League of Nations or the International Health Division of the Rockefeller Foundation,

5. by the provision of study leave for officers of the Colonial Medical Services at Institutions in the U.K. and in other countries.

The cost of these measures had been borne mainly by colonial governments; in a few cases the cost had been met, in part by funds from other sources such as the Royal Society, the schools of tropical medicine, the Wellcome Bureau of Scientific Research and the MRC.

In view of the great diversity of subjects in connection with which specialist assistance was required in the colonies, the CAMC recommended that any additional money available from the CDF should be used in extending the existing arrangements and in facilitating the interchange of officers between one colony and another and in providing for

study leave. They further recommended that the practice of interchange should be extended to include interchange between U.K. institutions.[53] In a letter to the schools of tropical medicine, the C.O. informed them that

> the possibility of introducing some scheme of the kind recommended by the CDPHC has been examined in this department but Sir Philip Cunliffe-Lister, Colonial Secretary, has reluctantly come to the conclusion that present circumstances would not justify his proceeding further in the matter.[54]

The decision of the CMAC not to endorse the proposal to attach supernumerary staff to the schools of tropical medicine meant that a colonial medical research service could not be established in the inter-war years. On the other hand, however, it also meant that any money made available from the CDF could be devoted to public health projects in general. But as a result of the difficulty experienced by the C.O. recruiting trained research workers for the colonies, medical research continued to be undertaken on an ad hoc basis. It was left for the research laboratories in the various colonies, staffed largely by officers who were medical men in the first instance, to undertake what research they could in the various colonies in which they served. Such research work was usually financed by the various colonial governments concerned.

The point to note is that these officers were mainly occupied with routine professional duties. They were far removed from the centres of modern scientific enquiry. In the circumstances, therefore, the medical services of the colonial territories, which in most cases were sparingly

manned, did not lend themselves to original research. In consequence the only alternative was to obtain men qualified as competent investigators to hold bacteriological and other similar appointments or to take part in special commissions of enquiry. The result was that individual territories began to organise their own research services. When a territory had more or less adequate medical staff and was in a position to devote funds to scientific purposes without unduly stinting its other requirements, a sum of money was voted either annually or at longer intervals for the express purpose of modern scientific research.

The failure of the CAMC to get financial assistance from the CDF on behalf of the colonial territories meant that individual colonial governments had to direct their applications for grants for research projects, if any, to the CDAC. The initiative had to come from the colonial governments themselves.[55] Thus, the CAMC.,like the ACTDRF before it, fell back on its usual routine of receiving and commenting on annual medical reports. The failure of the CMRC to survive as a research organization for the Colonial Empire and the additional problems of lack of funds for medical research caused the MRC, in 1936, to form the Tropical Medical Research Committee - a sub-committee of the Medical Research Council, of which the Medical Adviser to the Secretary of State for the colonies was a member.[56] Because of the dearth of trained investigators to study tropical diseases, the Council devised a scheme of junior and senior fellowships to encourage promising young workers

to enter this field and undergo special education and training. By the end of 1938, eight junior and three senior fellowships had been awarded.[57]

By 1936 also, medical research for the colonial empire had been overshadowed by the problem of colonial nutrition[58]. However, while efforts were being made in Britain to attain a better central organization for medical research - though indeed little was achieved in practice - machinery for medical research in the colonies remained loose and ill-defined.

MEDICAL RESEARCH IN BRITISH WEST AFRICA

Medical research in the British West African territories was centred in the clinical laboratories. The need for these laboratories had been noted by colonial authorities very early in their administration. In Lord Elgin's circular despatch of April, 1906, to colonial governments, he pointed out that the training which medical officers received in Britain was an essential preliminary to independent research. Consequently, they should be encouraged to undertake basic research work.[59] The governments in British West Africa expressed total agreement. Nigeria in particular called for the establishment of a Medical Research Institute, to be sited in Lagos. In June 1906, W. F. Forsbery, then Acting Governor of Southern Nigeria, in reply to Elgin's despatch pointed out that although the climates in the different

British administrations in the region varied a good deal, the diseases prevalent were common to the whole of West Africa. Therefore, if an efficient research institution was established in one, the enquiries pursued would be of use to all. He further added that the diseases could be better studied where cases were numerous than in countries where the diseases were exotic.[60]

The scheme to establish a medical research institute in Lagos went ahead and was completed by the middle of 1909. Its success, however, fell below what had been anticipated for two main reasons. First, it was commenced on too small a scale and secondly, it was separate from the administrative head of the Medical Department. There were only two workers and they could not hope to deal with the large amount of work, both routine and research, calling for investigation. In 1915, the Research Department was amalgamated with the Medical Department and in 1918 the Governments of the Gold Coast, Sierra Leone and the Gambia, who had contributed to the support of the Institution ceased to do so; the Gold Coast and Sierra Leone having built research laboratories of their own.[61] By 1923, Nigeria had a Medical Research Laboratory, a Clinical Laboratory and a Tsetse Investigation Team. By 1926 also, a pathologist had been appointed to each of the hospitals in Lagos, Kaduna, Port Harcourt, Warri and Calabar.

In 1930, the Gold Coast had the following laboratories: the Medical Research Institute, Accra; the clinical laboratory attached to the Gold Coast Hospital, Accra; the laboratory at Sekondi and a field laboratory at Yeji in the Northern Territories where sleeping sickness was investigated. There was also a laboratory in Kumasi, but this was hardly used as a result of the difficulty in obtaining the required staff. The senior staff of the Medical Research Institute consisted of a Director and two pathologists. The Gold Coast clinical laboratory, although in use, had difficulty in keeping a full-time pathologist because reliefs had to be found for other stations. One pathologist was responsible for the Sekondi laboratory and another for the sleeping sickness camp at Yeji.[62]

Sierra Leone had a clinical laboratory in Freetown which also served the Gambia. In 1921, the Sir Alfred Jones Research Laboratory was opened by the Liverpool School of Tropical Medicine with funds from Jones' estate. Its first director was Professor David B. Blacklock. The laboratory acted as consultant to the colonial government and reported on pathological material submitted for examination from Sierra Leone and the Gambia Medical Departments. The staff worked in close association with the medical staff of the colony of Sierra Leone and received an annual grant from the Sierra Leone Government. In 1928, an annual grant of £3,000 for three years was received from the Empire Marketing Board (EMB) to enable the Liverpool School to extend the scope of its work into metazoan immunity.[63]

The Liverpool School had always believed that research into tropical disease should be done not only in Britain but where the disease occurred.[64] Much valuable work was done by the staff of the laboratory. In 1925, at the request of the Government of Sierra Leone, the laboratory made a bacteriological examination of the water supply of Freetown, studied infant mortality and investigated black water fever, malaria and trypanosomiasis. Also with the help of the laboratory, the Government started a scheme for the examination of school children and also carried out an enquiry on the subject of the administration of quinine to school children.[65]

The laboratory also served as a most useful base for individual research workers who visited West Africa for special enquiries. In 1934, a serious outbreak of yellow fever occurred in the Gambia and at the request of the C.O. Dr. T. H. Davey, from the staff of the laboratory, accompanied by Dr. Findlay of the Wellcome Bureau of Scientific Research, spent some months in the Gambia immunizing the population and carrying out various investigations.[66] The laboratory was however closed down in 1941 for the duration of the war.

Apart from the Alfred Jones Research Laboratory, there was also the Rockefeller Yellow Fever Commission which conducted organized research in the region. In 1920, the Yellow Fever Commission of the International Health Division of the Rockefeller Foundation, with General R. E. Noble as

Director, arrived in Lagos. They could not start work immediately because there were no cases of yellow fever in the region at the time. However, yellow fever became active in the Gold Coast during 1923 when 22 cases were reported. In 1924 there were 13 cases, and in 1925 there were 10 cases in the Gold Coast and 21 in Nigeria; in 1926 there were 27 in the Gold Coast and 11 in Nigeria. During the year 1927 only two cases were notified in Nigeria but there were 107 cases in the Gold Coast with 41 deaths and the disease was known to be present in ten large towns.[67] These figures were not more than an indication of the true numbers because most of the cases were not notified.

During the same period, there was an epidemic in Senegal and cases were notified in the French Sudan, the Ivory Coast, Dahomey, Togoland and the Upper Volta. This outbreak was so severe that at the invitation of the Governor General of French West Africa, with the concurrence of the Governors of British West Africa, a conference was held at Dakar, Senegal, between April 23 and May 1st, 1928. The object of the conference was to enable the various governments to cooperate in studying the problems associated with the prevalence of yellow fever in West Africa with a view to elucidating the source or sources of infection and to explore any possible means of stamping out the disease.[68]

This outbreak, however, gave the commission an opportunity to open up their investigations. The West African Yellow Fever Commission was formally organized in

1925 with Henry Beeuwkes as Director. The commission's programme of work included investigations into the character of the disease; its epidemiology; its relation to yellow fever in the western hemisphere; the discovery of the areas where it was constantly present, the isolation of the organisms causing the disease and the methods of transmission.[69] The commission considered that these programmes must be carried through before they could undertake any control measures. However, the commission wound up its work in West Africa in 1934.

Apart from the work done by the Yellow Fever commission and the Alfred Jones Research Laboratory, the work done in the Research Laboratories of colonial governments was ordinary routine laboratory diagnosis and post-mortem examinations. Much of this work comprised the examination of clinical materials submitted by Medical Officers, the examination of mosquito larvae, rats, water samples etc. More often than not the diagnosis ended in detailed reports of the department and publications in medical journals.[70] Although much of the work was routine, the various British West African Governments found it difficult to get the required personnel to man the laboratories. In 1921, specialist posts were created in the West African Medical Service (WAMS) which made it possible for these territories to employ surgeons, dentists, entomologists, bacteriologist etc. By 1930, the Gold Coast and Nigeria had appointed eleven pathologists between them; three bacteriologists, three entomologists, a tsetse investigation officer and a

research officer. Sierra Leone had one pathologist and the Gambia none.[71] The number of appointments for the laboratory departments were indeed small. This problem was further compounded in the late 1920s and early 1930s, when, as a result of the economic depression, it became necessary for Colonial governments to cut down their budgets as well as place embargoes on the recruitment of scientific staff. In May 1930, Lord Passfield, Colonial Secretary, in a circular despatch informed olonial overnments in West Africa of the abolition of the post of bacteriologist. Also, the designation 'bacteriologist' was changed to pathologist. In addition, Colonial governments were informed that all officers selected for appointment in the WAMS would be selected as medical officers in the first instance. When it was necessary to fill a vacancy for a pathologist the DMS would chose a suitably qualified officer from among the medical officers and assign him for duty in the special post.[72] The problem of obtaining qualified personnel for research services was not peculiar to West Africa. Writing on East Africa, Julian Huxley maintained that, "most of the research workers started work as amateurs and had no scientific training".[73] It is no wonder therefore that most of them were pre-occupied with routine work.

By the mid 1920s however, some medical authorities in West Africa began to think that a change was needed. Dr. D. Alexander (the DMS, Nigeria) in his proposal for the reorganization of the scientific department maintained that,

> the development and carrying out of research is of the highest importance as it forms the bedrock of preventive and curative medicine; and is one which should no longer be neglected in a colony such as this in which the development of the country so largely depends on the health and increase of the population[74]

In 1925, Nigeria drew Amery's attention to the need for developing the facilities for medical research in the territory. Dr. Alexander's proposals involved the sub-division of what may be termed the scientific branch of the department, as distinct from the medical and sanitary branches, into two divisions: research and clinical. For the Research Branch, he asked for a protozoologist, a biochemist and an assistant bacteriologist. For the latter, he asked for five additional pathologists, four of whom would be stationed at Kaduna, Port Harcourt, Warri and Calabar, while one would act as relief.[75]

This proposal was designed in the first place to afford the Director of the Medical Research Institute adequate opportunity for research work proper. Secondly, it was designed to provide facilities for clinical investigation at hospital centres in Nigeria other than Lagos. No doubt, the value of clinical examination depended on the promptitude with which it was carried out. The prospect of having to wait for months for their results naturally deterred medical officers in the more remote districts from sending material to Yaba for examination. The need to establish clinical laboratories in provincial hospitals was thus a genuine one.

The proposal was however criticised by F. M. Baddeley, the Acting Governor, and by the Colonial Office. The Acting Governor expressed some doubt as to whether the interest of medical research would be best served by such an organization. He argued on the one hand that a research officer who found himself rooted in the same station, with the same kind of job, for a number of years until he attained the age of fifty and could claim a pension, might find it difficult to retain the enthusiasm which was essential to all research work. On the other hand, he argued that the Government could find itself burdened for many years with an officer who had lost his enthusiasm altogether or whose enthusiasm could be diverted from the lines of research most suitable to the needs of the country to some other subject which appealed to him personally. For these reason, he suggested that the Nigerian Government should rather endeavour to obtain the services of young and distinguished graduates of the Universities on contract for a period of time, liable to renewal by mutual consent.[76] Such officers were to be appointed on a temporary basis.

Baddeley's criticism was open to objections. First, a capacity for original research implied in itself exceptional mental vigour and what might be lost in freshness or originality of outlook by continuous service under the same conditions might well be balanced by experience. Secondly, research often requires years of work before it can show any results of practical value; different methods and types of enquiry appeal in varying degrees to different individuals and lines of investigation which are still uncompleted might

be prematurely abandoned with consequent waste of valuable work, as a result of frequent change of personnel. Hence, for effective research work, there was a need for continuity.

The Colonial Office, on the other hand, did not consider that a sharp distinction should be made between the clinical staff and the staff of the research department. They insisted that the staff of the Medical Research Institute should be capable of undertaking research as well as conducting ordinary clinical examinations and should be encouraged to do so as opportunities offered themselves. Thus the proposal to reorganize medical research in Nigeria was rejected but the C.O. accepted the appointment of five additional pathologists. In accepting the appointments, the Colonial Secretary pointed out that they were

> an addition to the laboratory staff at the disposal of the Head of the Medical Department both for routine and for research work at the institute or elsewhere as required.[77]

F. M. Baddeley's plan for recruiting the staff of the Medical Research Institute on a temporary basis was also considered inexpedient by the Colonial Office.

Similarly, in 1928, Governor Denham of the Gambia pointed out the need to establish a research bacteriological laboratory in the Gambia.[78] The C.O. saw no reason why the Gambia should require a laboratory equipped and staffed for actual research work. Indeed, they thought the idea of the

Gambia running a research laboratory "too ludicrous for words".[79] The Gambia had to be content with the attachment of a clinical laboratory at the Bathurst Hospital with the hope that it would be possible to obtain the occasional services of a pathologist from Sierra Leone.

It is thus evident that what was intended for the colonies was for the medical departments to undertake routine clinical work. Original research had to be based in the U.K. It was considered sufficient for the colonial territories to make annual contributions to research institutions in the U.K., who would undertake research on their behalf. Such research, however was beneficial not only to the colonial territories but to the world at large. For the support of these institutions, Amery, in May, 1928, sent a circular despatch to all colonial governments, suggesting the creation of a 'pool' from which grants to research institutions could be made.[80]

The implication of this policy was that medical research in the colonial territories in the inter-war years was geared towards the attainment of immediate results, i.e. curative medicine. This policy was further boosted by the fact that, by the end of the 1930s, valuable pioneer work on tropical diseases had been done by individual scientists in Europe and elsewhere as well as a number of scientific institutions. Thus medical officers were only required to diagnose the most prevalent of the tropical diseases and prescribe therapeutic drugs which had been discovered in Europe.

The first programme of organized research in West Africa was conducted by the Nigerian Tsetse Investigation Unit with headquarters at Sherifuri in the Northern Provinces. This scheme was an outcome of the proposal of the Imperial Bureau of Entomology that tse-tse fly research in Africa should be put on a more organized basis.[81] As a result of the diversity of the tse-tse problem in Africa, it was not practicable to inaugurate this scheme with funds contributed by the various territories interested in the problem. The suggestion, however, met with the approval of Sir Hugh Clifford, the Governor of Nigeria, and Dr. T. E. Rice (DMS) and it was decided to commence the investigation at once. The first investigators were Dr. W. B. Johnson, who began work in July, 1921 and Dr. Lloyd Llewellyn who began in September of the same year. By 1930, the tsetse fly investigation staff consisted of a Director, a deputy director, a senior Sleeping Sickness Officer (Medical Officer), three Sleeping Sickness Officers (Medical Officers), an entomologist, a biochemist and two laboratory attendants. By the end of 1933, Nigeria had five complete teams, each consisting of one medical officer, two nurses and twenty-four dispensary attendants at work in the field combatting trypanosomiasis.

At the beginning it was decided to make a rapid test survey of those parts of the country in which the distribution of tsetse was best known.[82] From the beginning of the investigations attempts were made to estimate the relative importance of the three prevalent species of

tsetse: Glossina palpalis, G. tachinoides and G. Morsitans. This was done by the study of the distribution of these species in relation to population, sleeping sickness and prevalence of domestic stock, especially cattle. Thus, from the outset, the unit was interested in the investigation of both human and animal trypanosomiasis.

In 1929, W. B. Johnson, who had recently been appointed the DMS for Nigeria, undertook a tour through a number of colonial territories (Belgian, French and British) to observe the general medical organization and methods of trypanosomiasis control in these Territories. At the end of his tour he came to the conclusion that there was need for a more general examination of the Nigerian population for Sleeping Sickness. The work of the Sleeping Sickness medical officer stationed in the Northern Provinces of the territory had proved that sleeping sickness was widely spread and was causing a disconcerting mortality and depopulation; but little was known of its range in the Southern Provinces and the Cameroons. As a result, medical officers were instructed to keep a look out for cases in their districts and report them to the Research Department.[83] Furthermore, he called for an additional appointment of a biochemist to be attached to the staff as well as a European laboratory attendant. The increased staff was necessary for increased control of human and animal trypanosomiasis and hence a reduction of mortality among the population and cattle. For this purpose, a grant was made by the CDAC totalling £7,800 to pay for the biochemist and the laboratory attendant.[84]

To further control the situation, a Sleeping Sickness ordinance was passed in 1936 with a view to preventing the spread of the disease in the Northern Provinces, especially in the mining areas in Niger Province. It was hoped that this could be achieved through compulsory examination of suspects, compulsory treatment of infected persons, and the compulsory eradication by employers of labour of conditions on their property conducive to an attack or spread of the disease.[85]

The treatment of the disease was also undertaken alongside actual scientific investigations. The mass treatment of sleeping sickness in the Northern Provinces was considered very important by the medical authorities. A number of new drugs were tried to prove their efficacy. The first of these was 'Bayer 205' (Geramin). From their experiments it was proved that 'Bayer 205' could cure the Nigerian sleeping sickness in the early stages of the disease and could cause improvement in the advanced cases.[85] Sometimes, the treatment experiments had adverse results. For example, in 1931, in the course of a campaign conducted in the Kaleri area of the Pankshin Division, Plateau Province, twenty-four deaths and thirty-five cases of blindness occurred as a result of the treatment with tryparsamide. The treatment was usually administered by the dispensary attendants under the supervision of a medical officer or a nurse. Sometimes, it was not possible for the medical officer, or even a nurse, to supervise personally all

the treatments. These occasional accidents might have been prevented if there had been more staff. Thus the work of control was often hampered by the limited number of trained personnel.

The Gold Coast on the other hand had no sleeping sickness investigation unit during the period under review. However, in 1927, tse-tse research was carried out at Yeji, on the Volta River, by A. W. S. Pemeroy, medical entomologist. His investigations were centred on the infection of cattle with trypanosomiasis, the bionomics of the species of glossina found, and the ecology of the area studied.[88] It was not until 1935 that the Gold Coast Government took steps to check the spread of trypanosomiasis in the territory, particularly the Northern Territories. The urgent need to check the spread of the disease in the Northern Territories stemmed from the fact that the supply of labour for the mines and cocoa plantations was derived mostly from this region. It was therefore necessary to ensure a sufficient and healthy supply of labour. In 1935 Sir Arnold Hodson, Governor of the Gold Coast, set up a committee to consider the problem of human trypanosomiasis. The committee recommended the establishment of a survey and general supervisory unit, the provision of clearing gangs to operate in the area that needed special attention, and the setting up of treatment camps in the badly infected areas.[89] The C.O. agreed that the survey should be made up of a medical officer and an entomologist. These should visit

Nigeria and spend some months making as complete a study as possible of the methods used by the Sleeping Sickness Unit in the Territory. This scheme never really took off until after WWII.

However, sleeping sickness in the Gold Coast continued to be treated in the hospitals as cases were diagnosed. Late in 1936, eleven people were reported dead at Bawku in the course of anti-trypanosomiasis treatment. Also in 1937, a tragedy occurred in Navrongo where nine patients died in the hospital.[90] In spite of the special attention given to the treatment of sleeping sickness, it was clear that the means were sometimes unsatisfactory. This raises the question of the effectiveness of the sleeping sickness measures adopted by the West African governments in the inter-war years. Generally speaking these measures emphasised pure scientific research and trials of therapeutic drugs. Little or no attention was given to the preventive aspect. The task of prevention could not be effectively pursued because it was expensive and colonial territories had to be self-sufficient.

However, by the late 1930s, the medical authorities of these territories increasingly began to press for preventive measures. The Nigerian Government, in 1936, applied for assistance from the CDF for anti-sleeping sickness work. These funds were needed to arrange for the concentration of population in protective clearings on the lines which had been found successful in Tanganyika Territory.[91] This

scheme involved the transfer of 70,000 people to model farms and villages and was also an experiment in proper feeding and hygiene conducted in an area made free from the tsetse fly.[92] Although approval was given, the scheme did not take off until after WWII. It was completed in 1946.

In Sierra Leone attention was drawn by two medical officers in 1939 to the prevalence of sleeping sickness on a large scale in the eastern part of the protectorate. As a result, arrangements were made for Professor Davey and Dr. Lourie of the Liverpool School to conduct a detailed survey into the incidence of the disease. Their report showed that the infection was more widespread than was at first thought and was in fact spreading. To gain control of the situation, the Sierra Leone Administration applied for a free grant from the CDF in 1939 but as a result of the war, the project had to be suspended.[93]

Apart from the stimulus provided by colonial governments the initiative for medical research in British West Africa also came from individual efforts made by colonial medical officers. Indeed, any illusion that the scientific output of the Colonial Medical Service was relatively meagre would be rapidly dispelled by a glance at the literature contained in journals such as the TRSTMH and the WAMJ. When the investigations recorded in other journals and in reports to Governments are considered, the total volume of work could be seen to be far from negligible. Naturally, these records varied considerably in scientific importance but many of them led to notable advances in medical knowledge.

Although few colonies were able to provide staff and facilities for full-time research, many valuable records were furnished by officers engaged in routine clinical, laboratory and preventive duties. The greater number of these records occurred in departmental papers dealing with specific local problems; thus, some of the most valuable information on trypanosomiasis, malaria and nutrition, was to be found in the Annual Reports of African territories.

During the late 1920s and early 1930s disorders of nutrition began to receive increasing attention, particularly in territories where it was suspected that many members of the population suffered from a state of chronic under-nourishment. The clinical syndromes of certain vitamin deficiency diseases had been recognized for years[94] but lack of precise knowledge regarding the chemical nature of the vitamins and failure to recognise the implications of various clinical signs and symptoms, had retarded systematic approach. Nevertheless some useful investigations had been carried out and workers in many territories were on the look-out for specific signs of defective food intake.

Dietary surveys were begun in 1927 in Nigeria under the auspices of the Medical Department. Dr. W. E. McCulloch carried out enquiries into dietaries of the Hausa and Town Fulani of Northern Nigeria. In 1931, he was relieved of his general medical duties so that he could devote his whole time to dietetic research. In the Kaduna Prison, McCulloch

studied the deficiencies of the ordinary Hausa dietary by investigating selected groups of convicts to find out if protein, calcium, salt or iodine, or several or all of these together were limiting factors in the nutrition of the Hausa male. Biochemical analyses of blood and urine showed wide variation in calcium content, a very low protein intake and a low salt excretion rate as well as a low blood chloride content.[95]

With financial assistance from the CDF, a Dietetics Research Laboratory was established in Katsina for experimental investigation by means of chemical analysis and laboratory animal feeding into the food value of a range of local foodstuffs commonly consumed in Nigeria.

In 1932 MacCulloch investigated the diets of school children in the Eastern Provinces of Nigeria where signs of avitamimosis were prevalent.[96] McCulloch resigned in 1933 and dietetic research was taken up and continued by Dr. J. G. S. Turner.[97] Turner investigated the possibilities of preparing a 'vegetable milk' from groundnuts, soya beans and various kernels; this would provide a useful alternative source of protein and other protective food constituents over extensive areas of Nigeria where animal milk was not easily obtainable. Turner wrote a pamphlet published in 1936 by the Nigerian Government, on "Food in relation to Health". This outlined the elementary principles for planning . . . local diets.[98]

Also in Nigeria, between 1929 and 1939, another member of the Medical Department, Dr. Fitzgerald-Moore , carried out valuable clinical investigations into certain common eyesight defects. He described changes inside the eye which sometimes ended in complete blindness. These eyesights and eye conditions were generally accepted to be manifestations of diet deficiency. He published a number of papers on the relationship between poor diet and bad eye-sight.[99] During 1934-36, Dr. Alfred Clark, under the auspices of the MRC, investigated and reported on certain aspects of poisoning by food plants, particularly cassava and cocoyam.

In the Gold Coast a peculiar syndrome which occurred in malnourished infants was described by C. William in 1933.[100] This syndrome which was known widely under its West African name of 'Kwashiorkor' was characterised by skin and mucus membrane lesions, oedema and gastro-intestinal disturbance. It was commonly attributed to the lack of more than one member of the vitamin B complex, associated with high carbohydrate - low protein intake. In 1939, F. M. Purcell produced a monograph on nutritional disorders in the Gold Coast. Although handicapped by lack of facilities for food analyses and other laboratory tests, he was able to define a number of clinical syndromes which were associated with malnutrition.[101]

As was to be expected, the dominant place occupied by malaria as a cause of morbidity and mortality in the tropics gave rise to a large number of investigations. Most of the

work was necessarily concerned with local aspects of the disease. For each territory had problems which were peculiar to its own particular kinds of environment. While advances in knowledge generally had a regional bearing, the variability of anopheline mosquito and malaria parasites made it necessary to examine each new finding in relation to local conditions. Thus the behaviour of a vector species, the action of an insecticide and the effect of a chemoprophylactic or chemotherapeutic drug must each be assessed for a particular region.

A report on a Nigerian method of testing anti-larval compounds under standard conditions was published in 1936.[102] B. A. S. Russell, in 1938, reported on the occurrence of macrocytic anaemia in pregnant women in the Gold Coast. She considered that this condition was related to diet and to malaria. She also undertook investigations on the treatment of malaria in children in the same territory.[103]

The picture that emerges after looking at medical research in the British West Africa territories in the inter-war period is that, although a number of research institutions had been established, these institutions provided, in the main, laboratory services. Some of the staff of the medical departments did undertake investigations into tropical diseases but the main emphasis of the investigations was the publication of their results in scientific journals. During this period also, the lack of coordination in the planning of medical research was very

obvious. Consequently there appeared to have been a division between the research conducted in the colonial territories, sponsored by colonial governments and Colonial Office initiative which involved attempts on a central organization of medical research. However, whether in the colonial territories or in London, a common problem that faced medical research was the lack of financial resources to sponsor research schemes and the difficulty of obtaining qualified research workers. In the colonial territories, medical officers were required not only for research work but also for routine duties in the medical and sanitary departments. How the Colonial Office tackled the problem of recruiting for these services is the subject of the next chapter.

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3. See for example, TDRF: Report of the Advisory Committee for the TDRF for the year, 1909. Cd. 4999.

4. With the establishment of the Dominion Office in 1925, the India Office was transferred from the Colonial Office to the new office; and the fund lost a major source of contribution.

5. See Michael Worboys. "Science and British Imperialism" (Ph.D. Thesis, Sussex University, 1979).

6. See Cmd. 1472 (1921): Report of a Committee on Research in the Colonies appointed by the Secretary of State for the Colonies.

7. Letter from J. H. Read (C.O) to Deans of the Universities in Britain. Enclosure in Cmd. 1472 (1921), op. cit

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9. Quoted in R. M. Macleod and E. K. Andrews "The Committee of Civil Research: Scientific Advice for Economic Development, 1925-1930" Minerva, vii No. 4 (1969), p. 683.

10. W. Ormsby -Gore "Opening Address to the League of Nations Conference on Sleeping Sickness in Africa" (London, May 19, 1925).

11. Cmd. 2744 (1926) Report by the Hon. W. G. A. Ormsby-Gore (Parl. Under Sec. of State for the Colonies) on His visit to West Africa.

12. Editorial Comment "West African Development" Nature 115, 30/10/26, p.650.

13. On production of raw materials for British industry see for example, A. G. Hopkins An Economic History of West Africa (London, 1973); W. K. Hancock A Survey of British Commonwealth Affairs: Problems of Economic Policy 1918-1939 (London, 1942).

14. Imperial Conference 1926 "Appendices to the Summary of proceedings", Cmd. 2769. p.319.

15. Memo by A.T. Stanton dated 2/4/27 in CO323/979/25541 (1927) Proposals for Colonial Medical Research Committee.

16. ACTDRF: Minutes of meeting held at the C.O. on 2/12/26 in CO323/979/25541 (1927), Ibid.

17. See for example Cmd. 3268 (1928) Memorandum showing the progress and Development in the Colonial Empire and in the Machinery for dealing with Colonial Questions from November, 1924, to November, 1928.

18. CO323/979/25541 (1927), op cit.

19. Memorandum by A. T. Stanton, op. cit.

20. The Colonial Office conference in 1927 was the first of its kind. It was attended by representatives of 26 colonial governments, and there was a general exchange of views on problems of common interest.

21. Cmd. 2883 (1927) Summary of proceedings of the Colonial Office Conference, 1927, Section XX, p.62.

22. G. Grindle (C.O.) to MRC dated 9/5/27 in CO323/979/25541.

23. Sir Walter Fletcher to C.O. dated 18/5/27 in Ibid.

24. CO323/979/25541 (1927) Proposals for a CMRC.

25. The name Tropical Disease Research Fund was changed to Tropical Disease Fund.

26. C.d. dated 28/2/28, Secretary of State to all Colonial Governments in CO323/979/25541 (1927), op. cit.

27. The survey was printed yearly from 1928 to 1930. Although it was not formally published, it was issued by the C.O. as "Memoranda on research in the Colonies, Protectorates and Mandated Territories".

28. For example, Dr. Pririe of South Africa was conducting research into plaque while cholera, dysentery, beriberi and malnutrition were being investigated in India. See "Medical Research in the Colonies and mandated Territories" No I September, 1928 (Issued by the C.O.); surgeons Twoe and A Barber.

29. Minutes of the 7th meeting of the CMRC held on the 23/1/29 in CO323/1046/60650 (1929) CMRC: Minutes.

30. Minutes of the 8th meeting of the CMRC held on the 27/2/29 in Ibid.

31. Minutes of the 9th Meeting of the CMRC held on the 7/3/29 in Ibid.

32. The influence of the MRC on medical research for the Colonial Empire is elaborately discussed in my chapter on the organization of medical research after WWII.

33. Minutes of the 9th meeting, op. cit.

34. Minutes of the 10th meeting of the CMRC held on the 24/4/29 in CO323/1046/60650 (1929).

35. Memorandum prepared at in the C.O. dated 15/1/30 in CO323/1050/60787 (1929) CMRC : Subcommittee on Finance and Personnel.

36. At the C.O. conference of 1927, it was proposed that the scientific and research officers in each of the technical services: agriculture, medicine, forestry, veterinary, should be formed into single services. This proposal was referred to a Committee of the conference, known as "Committee 'A'". In their Report, Committee 'A' recommended that the Conference should approve the principle of the ultimate creation of a single Research Service; the natural method of growth of such a service; the natural method of growth of such a service, however, was the

organization, in the first instance, of workers in the various fields of science in separate services. In the organization of these separate service the possibility of their eventual fusion into a common research service was to be borne in mind. Their main recommendations were generally accepted by the Conference.

37. See CMRC: Report of a Sub-Committee on Finance and Personnel, Op. Cit.

38. Ibid

39. Memorandum prepared by the C.O. concerning an application for £10,000 from the colonial Developing fund 15/1/30 in CO323/1050/60787 (1929) CMRC: Sub-Committee on Finance and Personnel.

40. In Nigeria for example , the entomologist attached to the Tsetse fly Investigation Team was seconded from the Department of Agriculture.

41. G. A. K. Marshall (Imperial Bureau of Entomology) to C.O. dated 18/1/30 in CO323/1089/70699 (1930) Medical Entomologists.

42. Ibid.

43. See for example Waterfield's letter (Treasury) to Sir Samuel Wilson (C.O.) dated 12/2/30 in CO323/1050/60787 (1929); Minutes of 13th Meeting of CDAC 22/1/30 in CO323/1090/70732/C.I. (1930) Medical work in the Colonial.

44. CO323/1090/70732/C.I. (1930) Medical work in the Colonies: CDPHC.

45. First Report of the CDPHC, paras. 16-19.

46. A. T. Stanton to Walter Fletcher, August 1930 in CO323/1112/71753 (1930) CMRC: Question of dissolution.

47. Walter Fletcher to C.O. dated 3/12/30, in Ibid.

48. Minutes of the 315th meeting of the CAMSC held on 17/2/31, in Ibid.

49. First Report of the CDPHC, 24/6/30 (C.O. Prints mis. 413.), p. 5.

50. See for example, University of Edinburgh to C.O. dated 10/3/31; London School to C.O. dated 4/2/31 in CO323/1142/80689 (1931): CDPHC.

51. Memorandum by W. T. Prout on the proposal to appoint additional staff to the schools of Tropical Medicine in connection with research in the Colonies (April 17, 1931)" in CO323/1142/80689 (1931), Ibid.

51. Minutes of the 318th meeting of the CAMC 21/4/31, in Ibid.

53. For details o the recommendations of the CAMC See Minutes of the 320th meeting of the CAMC held on the 16/6/31, in Ibid.

54. R. V. Vernon (C.O.) to LSHTM, LSTM and University of Edinburgh, 9/12/31, in Ibid.

55. The situation was different after the WWII when money for research in general was provided and the initiative for medical research was coming from London.

56. The MRC had always claimed that they conducted valuable research work for the Colonial Empire for which they felt Colonial Governments should make financial contributions. However, much of the work done by the Council was of a general application rather than for the benefit of the Colonies specifically. In 1934, the Council asked for contributions from Colonial Governments but the C.O. was not inclined to give its support. The main reason was that the C.O. did not was not want to add to the burdens of miscellaneous contributions which Colonial Governments made to Scientific Institutions in Britain. See for e.g. CO323.1266/30664 (1934)MRC.

57. Cmd. 5939 (1939), Report of the MRC for the year 1937-1938.

58. The problem of Colonial Nutrition is discussed in Chapter on Medical Research after WWII.

59. Lord Elgin to Colonial Governments dated 23/4/1906. Appendix I to Report of the Advisory Committee for the TDRF. Cd. 3306 (1906).

60. Forsbery (Acting Governor of Southern Nigeria) to Lord Elgin, 13/6/1906, encl. in Ibid.

61. See for example Charles Tettey "A brief History of the Medical Research Institute and Laboratory Service of the Gold Coast 1908-1927" WAMJ, 9, (1960), pp. 73-85.

62. Gold Coast, Report of the Laboratory Services for the year, 1929-1930.

63. Annual Report of the Liverpool School of Tropical Medicine for the year, 1929.

64. This belief was a major factor of controversy between Ronald Ross and Patrick Manson and hence between the Liverpool School and the London School early in the century. On this controversy see for example Michael Worboys "Science and British Colonial Imperialism".

65. Liverpool School, Annual Reports, 1921-1933.

66. CO87/240/4 (1935) Yellow fever; See also Annual Report of the Liverpool School for the year, 1934.

67. Figures compiled from CO96/674/4359 (1927) Yellow Fever Special Reports.

68. For a report on this Conference See Dr. P. S. Selwyn-Clarke (Gold Coast DDMS). Report of the Yellow Fever conference at Dakar, 1928 (Accra, Government Printer, 1929).

69. See for example Stanley F. Woodward "Early Days of Yellow Fever Research" WAMJ, 3, (1954), pp 43-44.

70. A majority of the contributions to the West African Medical Journal (WAMJ) established in 1927 were members of the WAMJ. These medical Officers, working on their own initiative, usually with extremely limited resources, had from time to time made important contributions to the knowledge of tropical diseases.

71. C.O. List (1930), p. 422.

72. CO879/123 (1930-31) Tropical Africa, Medical matters. Secretary of State to Governor of Nigeria, 5/5/30.

73. Julian Huxley Africa View (London, 1931), p. 14.

74. Dr. Alexander "Reorganization of Medical Research in Nigeria", 25/5/25 and in Nigeria No. 109 Ag. Governor (Braddeley) to Secretary of State dated 15/8/25 in CO879/122 - Tropical Africa, Medical Matters.

75. F. M. Baddeley, Ibid.

76. Ibid.

77. C. d. Colonial Secretary to the Governor of Nigeria dated 17/11/26 in CO879/122, op. cit.

78. Denham to C.O. dated 10/12/28 in CO87/228/2 (1929): Research Bacteriological Laboratory - proposals.

79. See minutes by J. F. W. Flood (C.O.) dated 29/1/29 in Ibid.

80. Secretary of State to Colonial Governments dated 3/5/28 in CO323/1001/50430: C.O. Conference 1927 Summary of action taken and recommendations.

81. CO583/113/58396 (1922) Tsetse Investigation.

82. Previous Surveys from this point of view had been carried out by Macfie in Ilorin Province. See Dr. J. W. Scott Macfie "Distribution of Glossina in Ilorin Province of Northern Nigeria" Bulletin of Entomological Research Vol. 4. PT.I and by Simpson. See J. J. Simpson "Entomological Research in British West Africa: Northern Nigeria" Bulletin of Entomological Research Vol. 2 PT.4.

83. See W. B. Johnson "Notes upon a journey through certain Belgian, French and British African Dependencies to observe general medical organization and methods of Trypanosomiasis Control". (Lagos, Government Printer, 1931).

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CHAPTER THREE

THE COLONIAL OFFICE AND THE PROBLEM OF RECRUITING FOR THE WEST AFRICAN MEDICAL SERVICES IN THE INTER-WAR YEARS

While the responsibility of providing increased medical and health services fell on individual colonial governments, it was the responsibility of the Colonial Office in London to recruit medical officers for the various colonial territories. In 1921, there were 133 Medical Officers in the establishment of the medical and Sanitary Department of Nigeria.[1] By 1931, the number had risen to about 173. This number of officers was to cater for the health needs of a population of about 20 millions.[2] bringing the ratio to one medical man per 115,606 population. This state of affairs helped to highlight the pressing need for the recruitment of more medical officers.

The demand for more medical officers did not emanate from a homogenous and organized service, but from separate and more or less independent colonial administrations, each with its own peculiar requirements and its own conditions of service. True, the rudiments of a more or less organized and unified service on a regional basis already existed in West Africa. In 1902, the British West African Medical Services were amalgamated to form the West African Medical Staff (WAMS). Thereafter regional medical services were formed in

East Africa, the West Indies and the Federated Malay States. It was not until 1934, however, that a unified Colonial Medical service was born, and this did not eliminate the problem of recruiting for these services.

RESULTS AND METHODS OF SELECTION

The Medical Departments of the colonial territories needed Medical Officers, Medical Officers of Health, sanitary inspectors, nurses and, from the 1920s onwards, research workers. Most of the officers who filled these appointments were recruited from Europe. Sanitary inspectors were recruited by the Crown Agents; while nurses for colonial service were recruited by the Overseas Nursing Association on behalf of the Colonial Office. Medical Officers and Medical Officers of Health were directly recruited by the Secretary of State for the Colonies.

Nurses for the colonial empire were recruited in the U.K. through the agency of the Overseas Nursing Association (ONA). The ONA was a voluntary agency founded in 1896 to provide trained nurses for hospitals and private work in British colonies and amongst British communities abroad. It was governed by a council and its general work was under the direction of an executive committee on which were two members nominated by the Colonial Secretary. There was also a nursing committee whose duty was to select candidates for nursing posts. In addition to selecting nurses, the ONA

maintained an active interest in the welfare of nurses and was able to use its influence to improve conditions of service, especially for nurses employed by colonial governments.[3]

For many years after the foundation of the ONA in 1896, nurses were engaged on short-term contracts and continuity of service was not as a rule considered, nor, in the early days, generally desired. Nurses generally served three years in a colony and then applied to the ONA for another appointment, and there was no recognized system of transfer. This lack of continuity brought problems and the committee of the ONA early began to examine the question of obtaining pensions for all overseas nurses, whether they were employed by colonial governments, municipalities or private nursing associations. In West Africa, a West African Nursing Staff was created in 1927. To standardise conditions of service, all nursing staffs in the four British colonies were amalgamated into a single West African Nursing Staff and all members were placed on one roster for promotion.[4]

Medical candidates for admission to the Colonial Medical Services had to possess a full medical qualification entitling the holder to be registered in the U.K. Unlike the recruitment of administrative officers where the 'Oxbridge' breed was preferred, no institutional preference (whether overt or covert) was placed on the recruitment of Medical Officers.[5] Thus candidates came from all medical institutions in the U.K. and Ireland. The Colonial Office sought as far as possible to secure candidates who had held

hospital or public health appointments or who had special knowledge of some particular branch of medicine or surgery. Great importance was also attached to post-graduate experience. However, unlike the Indian Medical Service and the Royal Army Medical Corps, the colonial medical services did not admit medical candidates through competitive examination. The method of recruitment was through what has been called "the patronage of the Secretary of State for the Colonies".[6] This was confined to those colonies and protectorates which were administered under his directions. In nearly all cases the vacancies for which medical officers were selected were in the junior grades of the services; while senior appointments were almost invariably filled by the promotion of officers. In most cases, the duties of a colonial medical officer were of a general character and included medicine, surgery, public health measures and research (in the case of officers with a flair for it). Specialist were rarely required; they were sought only for such tasks as taking charge of a lunatic asylum.

It had long been supposed that recruitment for service in tropical Africa could not be undertaken through competitive examination because its climate and diseases deterred many potential candidates. But in 1909 a Colonial Office Committee on the West African Medical Service declared that the unhealthiness of West Africa was often exaggerated and it recommended that vital statistics of the European official population of the West African colonies should be circulated to medical schools periodically.[7]

The image of the region as 'the White man's grave' was slow to disappear but improvements in the early 20th Century were understood well enough in official circles to reduce sharply the most serious impediment to recruiting for the Tropical African Services. In the inter-war years, as we shall see, the problem of recruiting for the West African medical service was no longer so much that of the danger to health as finding suitable candidates for the services as well as the limited financial resources of the colonial territories.

Before 1909, the examination for selection was conducted by the Private Secretary (Appointments) to the Colonial Secretary.[10] The Colonial Office Committee which reported in that year criticised the selection of professionals by 'laymen'. It recommended the establishment of a sub-committee consisting of two medical members and one of the private secretaries to the Secretary of State, to advise the latter on the selection of candidates for medical appointments.[8] This sub-committee was duly formed and by the mid-1920s consisted of Sir James Kingston Fowler, Dr. A. T. Stanton, Dr Horn (all prominent physicians) and Alexander Fiddian, private secretary to the secretary of state.

The selected candidates usually began by attending a course of from three to six months at the schools of tropical medicine in Britain. This was the course leading to the Diploma in Tropical Medicine and Hygiene (DTMH),

which practically all members of the Colonial Medical Services were expected to acquire either on their first appointment or at the first opportunity thereafter. The candidates' fees were paid by the Colonial governments.

THE SCHOOLS OF TROPICAL MEDICINE

The importance to Tropical Africa of the British schools of tropical medicine cannot be over-emphasised. In 1898, Joseph Chamberlain, as colonial secretary, addressed a circular letter to the General Medical Council and the leading medical schools in the U.K. urging that all medical officers selected for an appointment in the tropics should begin their careers with the requisite knowledge for dealing with tropical diseases. He further stressed that it was very desirable that before undergoing such special training, the future medical officers of the colonies should be given facilities in the various medical schools for obtaining some preliminary knowledge of the subject. "I would be prepared", he added,

> to give preference in filling up medical appointments in the colonies to those candidates who could show that they had studied this branch of medicine especially if some certificate or diploma to that effect were forthcoming.[9]

It was clearly advisable that a special training School in tropical medicine should be established where newly appointed Colonial medical officers might be given systematic instruction, with special facilities for clinical study, before taking up their appointments. The training

school would also provide facilities for doctors already in the service, who, when on leave, could have the opportunity of bringing their professional knowledge upto date. The result was the establishment of the London School of Tropical Medicine in 1899.

Just before this, the Liverpool School of Tropical Medicine had been established due to the energy and public spirit of Sir Alfred Lewis Jones, a Liverpool business man. He offered to give £350 per annum to the Royal Southern Hospital to promote the special study of tropical diseases.[10] Initially the Colonial Office offered little encouragement to the rapidly developing Liverpool School, but in 1900 it recognized the Institution's graduates on a par with London's for appointments in the tropics. The Advisory Board of the Tropical Disease Research Fund, created in 1904, granted each school an annual subsidy of £500.

The original course for the Diploma in Tropical Medicine was intended to provide doctors in colonial service with a comprehensive account of the diseases prevalent in the tropics and how to control them. It was found necessary to do this because the British medical curriculum of the time did not include a study of tropical diseases as they affected the colonies.

In 1928 the DTMH of the University of Edinburgh was recognized in the same manner as the Diplomas of London and Liverpool as a qualification for appointment as medical officer in the colonial medical services. A Diploma in tropical medicine from the University of Cambridge was also acceptable.

The proliferation of schools of tropical medicine in the U.K., although good in itself, brought in its wake great rivalry. The fiercest of these was between the London and Liverpool Schools. No doubt, this was to be expected as they were established within six months of each other. The disagreement between the London and Liverpool Schools has been recognized by a number of historians. Michael Worboys sees it largely in terms of the personal disagreement between Patrick Manson of the London School and Ronald Ross of the Liverpool School.[12] What most concerns us here is their competition for students and resources.

Candidates for the colonial medical services were ordinarily required to attend one of the following courses:-

a) A twenty-week course comprising both tropical medicine and tropical hygiene at the London School.

b) A six-month course in tropical medicine and hygiene at the Liverpool School.

c) A three-month (primary) course at Edinburgh University to be followed by a three-month second course.[13] Candidates were free to attend whichever Institution they preferred.

Candidates for appointment as Health Officers had further requirements. Those who had taken the London Course had to take the examination for the DTMH of the Cojoint Board of the Royal College of Physicians and the Royal College of Surgeons of England; those who attended the course in Liverpool or the second course at Edinburgh were required to sit for the examinations leading to the Diploma in Tropical Medicine and Hygiene of these Universities.[14]

The rivalry between the London and Liverpool schools for students of the colonial medical services and the rivalry over resources are inseparable. The rivalry came to a head in the 1930s primarily as a result of the decline in the number of medical officers attending the Liverpool course and the corresponding decline in grants from the colonial governments. The economic depression of the early 1930s caused a sharp decline in the number of appointments to the colonial medical services:

Year	Medical appointments[15]
1925	129
1926	97
1927	121
1928	81
1929	107
1930	77
1931	35
1932	12
1933	22
1934	31
1935	48

However, the falling-off in recruitment between 1929 and 1932 cannot alone explain declining demand for tropical medicine at Liverpool, since numbers in London held up well until 1932:

Year	London School	Liverpool School[16]
1925	69	13
1926	63	26
1927	69	17
1928	68	20
1929	64	25
1930	77	8
1931	58	8
1932	21	4

Four hundred and eighty-four candidates attended the London school between 1925 and 1932; while only one hundred and twenty-one attended the Liverpool school within the same period.

Some officials at the Colonial Office suggested that it should allocate candidates to the schools, for if they continued to have an entirely free choice few would elect to attend the Liverpool or Edinburgh courses.[17] The question of allocating candidates to the schools of tropical medicine had already been raised by the Liverpool school. In a letter to the Colonial Office, Lord Leverhulme, the chairman of the School, stated that, so long as the C.O. adhered to its system of recruitment before candidates had taken the DTMH, the choice of school should not be left solely to the officers themselves, but that they should be drafted to the schools in agreed proportions - say, for every three students, one went to the Liverpool school and two to the London School.[18] However, by the time the Colonial Office arrived at a decision to allocate candidates to the three schools of Tropical Medicine, the second world war had broken out; ironically, the London course was suspended while that at Liverpool was continued.[19]

From its inception, the colonial territories were made to make annual contributions to the London school. In 1904, when the Advisory Board of the Tropical Disease Research Fund was created, they took over the management of these funds and an annual contribution of £500 was made to the Liverpool school as well. Contributions to the Liverpool

school were soon stopped and the only colonial territory that continued to make annual contributions to the school was Sierra Leone, Since the Alfred Jones Research Laboratory - an Institution of the Liverpool School, opened in 1921 - was located in Freetown.[20]

In lobbying for more contributions from the colonial governments, Austen Chamberlain, the chairman of the Court of Governors of the London school , wrote in 1935,

> the work we do in training men for the CMS and especially the fact that medical men already in the service come to the school to take special courses when home on leave give us, I submit, a real claim upon the support of Colonial Governments which receive the benefit of our labours.[21]

If this argument was valid, colonial governments should equally have made annual contributions to the Liverpool and Edinburgh Schools. Naturally, the Liverpool School was aggrieved that such contributions were not coming their way. In a letter to the Colonial Office the Liverpool School suggested that grants from colonial governments should be allocated to the various schools in an agreed proportion.[22] To this, the Colonial Office replied that such contributions were voluntary and were for the most part a result of long-standing arrangements between the various governments concerned. Hence the Secretary of State could not see his way to interfere.

The only exception was Ceylon, who, in 1935 entered into a special arrangement with the London School. It was a condition of their contribution that a certain number of free courses should be provided to postgraduates. Other Colonial governments paid the fees for their medical officers to the school as well as the annual contributions. What the Colonial Office was unwilling to admit was that the London school received exceptionally favourable treatment compared to the other schools of tropical medicine. This was difficult to justify. The Colonial Office, since Joseph Chamberlain's time, had supported the London School in obtaining subsidies from colonial governments of about three thousand pounds per annum.[23] Thus the obvious course was to encourage colonial students to attend the London School, as the more students it got, the less it would need colonial subsidies. There is no doubt that for a long time the London school survived on the patronage of high government officials. On the other hand, one is bound to question the need for three schools of tropical medicine in Britain at this time.

RECRUITMENT FOR THE WEST AFRICAN MEDICAL SERVICE BETWEEN THE WARS

One of the most urgent problems that confronted the Colonial Office after World War One was how to fill the vast gaps left in the service by the virtual cessation of recruitment during the war years. At the same time, the war had dislocated financial and economic arrangements in varying degrees throughout the colonial empire. In Britain

the war had halted new entries to the Medical Schools and there was shortage in the supply of qualified doctors. Also, on account of the longer time required for training, the effect of this shortage was felt over a longer period than in other technical services.

Meanwhile, the demand for doctors in Britain itself was greatly increased owing to the expansion of various social services, while in Africa there were the needs of new British territories: Tanganyika, part of Togoland, and western Cameroon. In addition to this, the medical services of the older territories underwent very rapid development as shown above. This state of affairs was further compounded by the outbreak of epidemic diseases in the 1920s.

To emphasise the acute shortage of medical personnel in Nigeria, the Chief Secretary, F.M. Baddeley, recorded in 1925 that normally there was no medical officer, no sanitary officer and no medical centre from Kano through Maiduguri to Yola, and in the Southern Provinces, in the whole of the Ijebu and Ondo Provinces; while in several large provinces, for example, Ilorin, there was only one medical officer. Some two or more stations had to be served by one medical officer.[24] Thus as Dr. Alexander, the DMS for Nigeria, pointed out, there were in that year (1925), no less than twenty-six vacancies in the cadre of medical officers, and he requested the Government to make renewed efforts to fill them.[25]

The situation was similar in the other British West African colonies. Although there was a slight improvement by 1928, there were still several vacancies as the table below shows.

Medical Officers:

Colony	Authorised Strength	Vacancies[26]
Gambia	6	0
Gold Coast	100	20
Nigeria	161	27
Sierra Leone	26	0

In the inter-war period, there was an increasing emphasis on preventive medicine and hence sanitation in West Africa. In response to the outbreak of epidemic diseases, there was an increased demand for medical officers of health, but the prospects for obtaining qualified recruits were very limited. Few of those who presented themselves for appointment already possessed the requisite Diploma in Public Health, and this took at least a year to acquire. In any case it does not seem that the Colonial Office was interested in encouraging preventive medicine in the colonies at the time. Officials there argued that preventive medicine appealed to few medical men largely because the nature of work involved varied widely in different parts of the world. For this reason, it was thought undesirable to select candidates in Britain for public health work before they had had practical experience of the conditions in the colonies.[27] It was therefore left

open to medical officers in tropical countries who so desired to apply to be appointed as health officers. Thus the desire of colonial governments for qualified health officers was hardly ever satisfied. In a memorandum prepared at the Colonial Office in 1932, it was clearly stated that all officers selected for appointment by the Secretary of State were appointed as medical officers.[28] When it was desired to fill a vacancy for a health officer, the DMS of the Territory would select and assign for duty in the appointment a suitably qualified officer from among the medical officers. The reluctance shown by the Colonial Office in committing themselves to recruiting qualified health officers goes a long way to explaining the predominance of curative medicine in the colonies before world war two.

The British West African governments tried to attract suitably qualified candidates by making the West African Medical Service more attractive. Following the inflation during and after WWI, salaries and pensions were revised. From 1920, the initial salary for a medical officer of the WAMS was £660 per annum, rising by £30 annually with proficiency pay of £72 per annum (Proficiency pay was drawn only in the colonies and was not pensionable).[29] In 1931, in a state of financial crisis, most West African Governments placed an embargo on recruitment of medical officers. Although there were still some vacancies in Nigeria (10), the Gold Coast (7) and Sierra Leone (2), these territories had written asking the Colonial Office not to

make any new appointments.[30] Nonetheless, the Colonial Office did not relax its efforts to obtain suitably qualified candidates. Several steps were taken to improve recruitment for the Colonial Medical Services. The initiative was taken by the Colonial Advisory Medical and Sanitary Committee (CAMSC).

One of the issues that came under discussion was the quality of medical candidates, Dr. Horn, the medical secretary to the CAMSC, remarked in 1924 that "our candidates are generally mediocre and even lower as regards standards of qualification and experience"[31]

In the same year, in a report to the CAMSC, the medical appointments sub-committee also observed that a considerable proportion of the candidates interviewed since the war were of a mediocre character and admitted that many of them did not appear to be suitable for the Colonial medical services.[32] The main reason was that many of the candidates were without clinical experience. This situation arose as a result of the influx of students to the universities after the war. By the late 1920s, they were obtaining qualifications but it was not possible to increase pari passu the number of resident appointments in the hospitals. Thus, the Medical Appointments Sub-Committee recommended that candidates who had recently obtained their qualifications should be seconded for a period of not more than six months to enable them to take up resident appointments.[33] Sir James Fowler, Sir John Bradford and Dr. Horn, the professional members of the committee, were

strongly of the opinion that clinical experience, such as that gained by holding a resident appointment, was of great value.[34] This system appealed to some members of the Committee because it was in force in the Royal Army Medical Corps (RAMC).

Some Colonial Office Officials considered that the new recruits, after three months at the tropical medicine school, might just as well practise on Europeans and Africans in the tropics.[35] But it was impracticable in the colonies to attach junior officers for any considerable period of time to a more experienced officer so as to gain experience in general practice: as soon as a junior officer was accustomed to his new country and general conditions he was normally required to take up a station on his own. The proposal for clinical attachment in Britain was accepted in principle by the Colonial Office, but was deferred until more of the outstanding vacancies had been filled and in fact it was never implemented.

This failure induced some members of the committee to suggest that there should be a common qualifying examination for the colonial medical services. This recommendation, it was believed, would not only attract better qualified candidates but would also advertise the service to the general public and thus increase its prestige.[36] The man behind this proposal was Sir John Fowler, who proposed a single qualifying examination not only for the colonial medical services but also for other services, such as the

RAMC and the Indian Medical Service.[37] One of the main obstacles to implementing this proposal was that there was no colonial medical service as such: individual colonies or groups of colonies, such as British West Africa, operated their own medical services with their own terms and conditions of service. This issue was never pursued because it was raised at an inopportune time, when there was a great shortage of medical candidates.

The CAMSC thus failed in its attempt to attract better qualified medical officers for the CMS. The Committee had been intended to provide a link between the Colonial Office and other agencies, such as the Schools of Tropical Medicine and the University Appointments Boards, which were the major extraneous bodies through whom candidates for medical appointments were obtained.[38] This objective was never satisfactorily achieved. The failure of the Advisory Committee to initiate and implement change concerning medical and health matters in the colonies stemmed largely from the fact that the committee was only advisory and had neither executive nor administrative powers. Indeed, all the professional members, except the medical secretary, were part-time and thus not fully committed to the cause of medical and health questions in the colonies. For the most part, whenever they were able to meet, it was to discuss and comment on medical and sanitary reports from the colonies. It was no wonder, then, that the professional members, recognising their lack of executive power, decided to seek

the appointment of a Chief Medical Adviser (CMA) in the Colonial Office, in the belief that such an official would give them direct access to the Colonial Secretary, and a greater say in shaping policy.

THE CREATION OF THE POST OF CHIEF MEDICAL ADVISER TO THE SECRETARY OF STATE

The origins of the appointment of a Chief Medical Adviser to the Secretary of State may be dated to 1920, when the Egerton Committee on colonial medical services reported in favour of the proposal that

> an officer of standing in the medical profession whose opinion would have weight with the secretary of State and whose name would create confidence in the medical profession should be appointed a member of the Colonial Office staff.[39]

After considering the views of various colonial governments, Winston Churchill, the then Colonial Secretary, decided against it.[40] In 1923, Sir Herbert Read revived the proposal when he proposed the appointment of Andrew Balfour as Sanitary Adviser to the Secretary of State, [41] but instead Balfour was appointed Director of the London School of Hygiene and Tropical Medicine.

This proposal was revived in 1924 by L. S. Amery, the new Colonial Secretary, who thought it essential to supplement the existing machinery of the Colonial Office for dealing with medical and sanitary matters and especially recruitment of medical staff.[42] He received support from his parliamentary under-secretary, Ormsby-Gore:

> on general grounds I would welcome the addition to the Colonial Office staff of a medical man of standing who would advise you on all medical reports received from all colonies and Protectorates; on all questions of medical research and staff in the colonies; and act as our Liaison officer with the various medical organizations and Research Councils and Bureau in this country.[43]

Ormsby-Gore further suggested that the new appointment should be paid for by Imperial funds rather than by contributions from colonial governments but this suggestion was firmly resisted by the Treasury. On July 1, 1925, Ormsby-Gore, Alexander Fiddian, Sir William Prout, George Buchanan, Andrew Balfour and G. E. J. Gent (Private Secretary) met to discuss the appointment. The conference agreed that the new Chief Medical Adviser (CMA) should be a Colonial Service man with experience in tropical diseases and research; and that the status of the new appointment should be equal to that of the Head of a department in the Colonial Office and not superior. Members of the Conference recognized that if the post was to succeed it was essential to secure the good will and cooperation of heads of departments.[44] The position was to be held for a term of three years on a salary of £1,500 per annum, with the option on either side to renew for a further period of three years. The post was to be non-pensionable.

On receiving the committee's report, Amery decided to recommend the immediate appointment of a CMA who would be charged with the following duties:-

1 To advise the colonial secretary generally on all medical and sanitary matters and for this purpose to have access to all necessary departmental documents.

2 With a view to the improvement of sanitation in the Tropical Dependencies, to ensure so far as was possible continuity of policy, coordination and action between different administrations and the introduction of new ideas in the work of the CMS.

3 To maintain a personal liaison and cooperation with other governmental departments and other bodies in relation to health work in the colonies and to keep in touch with the medical schools in the U.K.

4 To preside over the CAMSC

5 To advise the Colonial Secretary on all matters relating to the personnel of the CMS.

6 To assist in the interviewing and consideration of candidates for appointment as medical officers in the Colonies, and to be a member of the sub-committee on colonial medical appointments.

7 To advise on all changes in the regulations of conditions of the employment of colonial medial officers and

8 To be accessible to all officers in the CMS who might wish to see him when on leave in the U.K.[56]

It remained to persuade the Treasury to accept the new appointment, since it was intended that the post should be paid for from Imperial funds.[46] Amery wrote a personal letter to Winston Churchill, then the Chancellor of the Exchequer, stressing that

> nothing could contribute more to improve efficiency and closer cooperation of our medical services in the colonies.... the idea has been unanimously and enthusiastically welcomed in medical circles, and was also warmly approved when I referred to the matter in the House on the Estimates.[47]

Nonetheless the Treasury replied that the appointment of a CMA was unnecessary and indeed undesirable. The Treasury also expressed the fear that the appointment of a CMA in the Colonial Office could be "small beginnings of a Health Department".[48] Instead the Treasury proposed that the salary for the post should be borne by the various colonial Governments.[49]

The BMA had long insisted that conditions of service of the colonial medical service officials were not attractive. In October, 1925, a deputation led by Professor R. A. Boland, chairman of the Council of the BMA, recommended to the Colonial Office that gratuity of officers of the WAMS who desired to retire after nine years service should be increased from £1,000 to £1,500; that the gratuity payable after twelve years service in that staff be £1,875; and that similar gratuities be instituted in the East African Medical Service or even made general throughout the Colonial Medical Services. They insisted that if the Colonial Office

were unable to comply with these recommendations then they could employ local men or non-Europeans if necessary.[50] This threat might have been a bluff on the part of the BMA but it was one which the Colonial Office took very seriously. Consequently, in March, 1926 G. Grindle, the permanent under-secretary, wrote to the Treasury stressing the need for such an appointment.

> I am glad that subsequent events and in particular a serious difference of opinion between the secretary of state and the BMA, which is interfering very gravely with the supply of candidates for the CMS, have gone far to confirm the secretary of State's view that an appointment of this kind [CMA] is imperatively necessary in the interest of the efficiency of his department.[51]

But it took something else to change the mind of the Treasury.

At a meeting of the Financial Committee of the Colonial Office the Chancellor of the Exchequer had expressed the wish that he would be very satisfied if in the Estimates for the Colonial Services, 1926, the figures of £510,032 could be reduced to £460,032. In fact, the figure was reduced to £446,000. As a result, the Colonial Secretary felt sure that the Chancellor would feel disposed to meet his request for the appointment of a CMA in the Colonial Office.[52] In a private letter to L. S. Amery, Winston Churchill did not pretend to be convinced of the need for such an appointment but he had no choice other than to give his sanction as a gesture of inter-ministerial favour. He was however careful to warn that the appointment of a CMA should not be a first step towards the establishment of a medical department

inside the Colonial Office.[53] Thus, with reluctance the Treasury sanctioned this appointment for a period not exceeding three years from April 1, 1926. Dr. A. T. Stanton, formerly Director of Government Laboratories in the Federated Malay States, was appointed to the post, and he took up his duties after retirement on August 1, 1926.[54]

The appointment was seen by officials at the colonial office as an unquestionable success and indeed it led to similar appointments in the Colonial Office e.g. the appointment of a Labour Adviser. After his first term of office, A. T. Stanton was reappointed. His reappointment meant the post had come to stay. Indeed the usefulness of the post made a Colonial Office official comment " I cannot see this office (Colonial Office) getting on without it [ie. the post of CMA]"[55]

Sir Ralph Furse, in his Aucuparius, maintained that the appointment of a CMA improved recruiting standards.[56] However, the same could not be said for improvement in the numbers of medical officers recruited because the difficulty of recruiting for the Service remained endemic in the inter-war years. Furthermore, in addition to the qualified medical officers required in the hospitals and public health services of the colonies, there was an increasing demand during this period for officers with specialist training in protozoology, biochemistry, entomology, bacteriology and pathology to provide for laboratory assistance in the diagnosis and treatment of diseases and medical research.[57]

Certainly the presence of a CMA in the colonial office made it possible for negotiations between the BMA and the Colonial Office to be conducted on a professional basis and no longer by 'laymen'. As mentioned above, the BMA, more often than not, had been unfavourably disposed towards conditions of service for medical officers serving in the colonies. Negotiations between the two bodies had resulted in an amicable settlement on practically all points of difference.[58] Personal contact was also established with the Deans of Medical Schools in Britain. This was made possible by the fact that the CMA was a member of the University Appointment Board. Yet, in spite of the personal efforts of the CMA to improve recruitment for the CMS, it had become apparent that from a professional point of view the CMS was still the least attractive service, compared to either the Indian Medical Service or the Royal Army Medical Corps. Recruiting prospects remained bleak for the CMS. It was in a further attempt to improve the situation that the Secretary of State appointed a committee to consider the existing system of appointment to the Colonial Office. The committee recommended the unification of the colonial services.

UNIFICATION OF THE COLONIAL MEDICAL SERVICES

In 1919, a Departmental Committee under the chairmanship of Sir Walter Egerton, had proposed the unification of the Colonial Medical services but it was then believed in official circles that the time was not yet ripe.[59] The main stumbling block to unification had been that conditions of

service differed from territory to territory. At the Governors' conference called by the Colonial Office in 1927, it was recommended that a united service for the Colonial Empire be set up. A committee under the chairmanship of Sir Warren Fisher (Permanent Secretary to the Treasury and Head of the Home Civil Service) was appointed in 1929 to consider the whole question of appointment to the Colonial Services. The recommendations of this committee were in favour of unification.[60]

In June - July 1930, a second Conference of Governors was held at the Colonial Office. This formed a sub-committee (chaired by the governor of Uganda, Sir William Gowers to consider the question of unification. In the light of its discussions, the governors' conference recommended the unification of the colonial services.[61] Passfield also set up a Committee to work out a scheme for unification. In the case of the Colonial Administrative Service, this soon bore fruit, but it was not until 1933 that a sub-committee of the CAMSC, headed by A.T. Stanton (CMA), was set up to consider proposals for the unification of the Colonial Medical Services. Thereafter, progress was rapid and these services were in principle unified from January 1, 1934. In principle also, the East African Medical Service and the West African Medical Staff no longer existed. Members of these services recruited before December 31, 1933, still belonged to the EAMS or the WAMS, as the case might be, but officers selected from January 1, 1934, belonged to the unified CMS. These officers were liable to be transferred, at any time, by the Colonial

Secretary from one territory to another.[62] The regulations of the unified service, as framed, only allowed the admission to the service of officers who possessed a medical qualification entitling them to be registered in the U.K., whereas officers recruited locally were regarded as members of the local administrations. The regulations also provided that, subject to the preservation of existing rights, no officer of the CMS would be entitled, as of right, to private practice. However, the implementation of the latter was not pursued because it was thought this would undermine recruitment prospects as private practice, especially in the West African territories,was supposed to be a major attraction of the service.

The main issue raised in the proposal for unified services was whether they would have a good effect on recruitment. Some argued that an obligation to compulsory transfer would have a deterrent effect on recruitment and that there was no practical evidence to show that such an obligation was indeed necessary. Others believed that the wider career prospects inherent in unification would make the colonial services more competitive with those of India and the Sudan.[63] However, by comparing the CMS with the Indian Medical Service, officials failed to recognize the basic differences of climate, position, cost of living and even conditions of service between India and the British East or West African colonies for example. Above all, the authorities concerned failed to take into account the fact that the Colonial Empire was made up of a number of colonies, Which existed as separate political units, each

with its own public service, organized according to its particular needs. Thus the unification of neither the Colonial Medical Services nor of any other service improved recruitment. Indeed the unification of the CMS never really took place.

In 1934, a Colonial Office memorandum relating to medical appointments in West Africa remarked that for all practical purposes the West African colonies and protectorates would be grouped together for purposes of conditions of service. Furthermore, although the publication of a common staff list for the WAMS would be discontinued, for practical purposes, a common staff list would be maintained. It was further stated that candidates should, on no account, accept an appointment for service in West Africa in the expectation of ultimately being transferred elsewhere; for, although officers of the CMS were eligible for consideration for appointment in the service generally, in practice opportunities for transfer could not be entertained until an officer had served for five years in any one territory.[69]

Besides, salary scales continued to vary in different territories. In West Africa, a medical officer was appointed at £660 a year, rising by an annual increment of £30 to £720 per annum; Whereas in East Africa Medical Officers were appointed at £600 a year rising by annual increments of £25 to £700. Similarly, the expected result of improved and increased recruitment for the CMS never

really materialised before the outbreak of WWII. Recruitment figures achieved in the 1920s could not be achieved in the 1930s. Recruitment for the entire Colonial Medical Services between 1924 and 1930 (inclusive) stood at 711, while the figure for the period, 1931 to 1937 (inclusive) was 248.[65] Thus, by the eve of the war, recruitment for the CMS had declined by more than 200 per cent.

The differences in conditions of service in the colonies was seen as a factor acting against the introduction of compulsory transfer. It was argued by Hemmant, a member of Sir William Gower's[9] committee on unification, that such a liability would deter recruitment.[66] There should, indeed, have been no cause for alarm. Officers could not have been moved from one colony to another just for the sake of doing so. At the same time, it would have been pure camouflage to talk of a single service if there was no obligation on the part of its members to move from one territory to another if the Colonial Secretary thought fit. Indeed, as regards the issue of transfer, nothing really changed in the case of West Africa. Junior officers were never transferred from on colony to another. The transfer of Senior Officers was usually done on promotion. This system already existed in the WAMS. With the institution of a unified service, however, senior officers of the service were transferred, as in the past, on promotion. For example, a Deputy Director of Medical Services in the Federated Malay States, could be transferred to a West African colony to head the medical

department in that particular territory. This system was not new; it was merely an extension of a system already in existence. Also, as in the past, the Colonial Secretary did not make such transfers on his own but in consultation with the government of the territories concerned.

Why did unification not attract candidates to the CMS? Generally speaking, the failure to attract the right type of candidate in sufficient numbers to the CMS could be attributed to the general loss of interest in the service, unified or not. There were a number of reasons for this loss in interest. During the depression years, a large number of highly qualified and experienced candidates, personally recommended, in many cases by deans of the medical schools, could not be placed on account of paucity of vacancies. Hence, the CMS became known in the medical profession as a 'Closed Service.[67] Secondly, the retrenchment of a number of medical officers in certain dependencies and the embargo on recruitment by many colonies in West Africa caused a good deal of uneasiness in the profession. A career in any of the colonial medical services was therefore regarded as insecure.[68] Thirdly, the conditions of service and opportunities for employment of medical officers in the fighting services, the Indian Medical Service and the Sudan Medical Service, and in Britain generally had been greatly improved since WWI. The London County Council and local authorities, for example, had increased their establishment and improved their terms of service. The newly qualified doctor was in greater

demand and could earn about £350 per annum, with quarters, as an assistant in general practice.[69] Fourthly, there was the policy in some colonies that married officers should not be accompanied by their wives nor children. This policy was most seriously implemented in the WAMS. For this reason, some of those who did apply were most averse to serve in West Africa. Nigeria, for example, realised that this policy did not in any way encourage the recruitment of medical officers for the territory. Accordingly, in 1926, its governor informed the Colonial Office that this policy was to be discontinued.[70] This change of policy, however, made little or no impact on recruitment because the major issue seemed to have been that salaries must continue to be increased, the maximum of long grade scales must be raised and promotion prospects increased. But colonial budgets could not permit this.

As a result of this general loss of interest in the CMS, there were moves in the Colonial Office to set up a committee to consider the recruitment of officers for the CMS and to make suggestions for improving the supply of candidates. This committee never met because of the outbreak of war.[71] But it is doubtful if it would have helped to improve the situation.

Meanwhile, in pursuit of the policy of unified services, Malcolm MacDonald, in 1939, initiated the unification of the Nursing Service. The service was unified in 1940 as the Queen Elizabeth's Colonial Nursing Service. In a letter to the Overseas Nursing Association, Charles

Jeffries pointed out that the aim of unification was to maintain and improve the efficiency of the service by enabling staff of "high personal and professional qualifications to be recruited".[72] Similarly, in notifying the colonial governments of his intentions, Malcolm MacDonald remarked that the formation of the Colonial Nursing Service would provide the nursing staffs with opportunities for promotion and transfer outside the territories in which they served.[73]

These arguments were often put forward as justifications for unifying the various colonial services. The latter was particularly used to bar locally recruited candidates from joining the unified services. In actual fact, the unified services were professional associations, officially recognized by the Colonial Office, which set out to protect the interests of its members. In the colonial situation therefore, the dichotomy between indigenous and expatriate employees of Colonial Governments was very obvious - a situation which the growing numbers of politically conscious West Africans came to resent and which their sympathisers attacked.

THE RECRUITMENT OF AFRICAN MEDICAL OFFICERS

Prior to 1902, African medical officers were frequently employed in the Government Services on a par with Europeans.

Dr. Easmon, who, at one time was Principal Medical Officer in the Gold Coast, was an African as also was Dr. Renner of Sierra Leone. There was also Dr. Waldron of the Gold Coast and Dr. Quartey-Papafio, also of the Gold Coast.[74]

In 1902, a committee was appointed in the Colonial Office to discuss the amalgamation of the medical services in West Africa.[75] As a result of their report, the West African Medical Staff was established. With regard to the employment of Africans, the committee was strongly of the opinion that it was inadvisable to employ 'native' West Africans as medical officers in the Government Service. They regarded it as the duty of both the Colonial office and colonial governments in West Africa to provide the best medical assistance in their power to their European employees. The committee's recommendations reflected the prevailing circumstances of the day. This was a time when government medical services was available only for Europeans.

One might have supposed that once it became government policy to try to extend medical facilities to the indigenous population, the two services would have accordingly been amalgamated, but this was not to be. The arguments put forward in the Colonial Office against the inclusion of Africans in the WAMS were as follows:-

1 It would adversely affect recruiting, which after a period of great difficulty since the war was then showing improvement, both in numbers and quality of candidates.

2 It would certainly lower the prestige of the WAMS as 'native' medical officers for the most part fall far short of the European doctors, both in professional ability and in the standard of their conduct.

3. It would not really confer any benefit on the Africans because no one suggests that they should be given the same salaries, leave conditions etc. as Europeans.

4. If African medical officers are kept distinct they can be confirmed to practice among their own people. If they are placed on the same level with the Europeans, it will be impossible to avoid putting them in sole charge of stations where Europeans live.[76]

On the first point, there was no question of Nigeria or the Gold Coast objecting to recruiting African doctors from Sierra Leone or vice-versa. As a matter of fact, Nigeria in the past had recruited a number of African Medical Officers of Sierra Leone origin. As to the second point, African doctors, and indeed African civil servants in the first half of the 20th century had been regarded as failures by Europeans.[77] This accusation was in fact baseless as Sir Alan Burns, referring to the same issue after WWII, remarked:-

> It is easy enough to find faults in Africans; to point out examples of African officials who have failed in character and integrity, and to demonstrate their incapacity for difficult or responsible work - but there have also been European officials who have done no credit to the service. There are bound to be failures in any civil service - whether in Africa or elsewhere.[78]

What was important is that the European civil servant saw senior posts in West Africa and indeed in the rest of the Colonial Empire as an exclusive preserve and would do anything to preserve not only their jobs but their careers. In the case of the WAMS, therefore, European officials did not object to the employment of Africans by colonial governments; but they saw 'no reason to give them the same salary or admit them to the same service as the European Medical Officers.[79]

The BMA had always emphasised that medical candidates who came up for employment must have qualifications registrable with the General Medical Council (G.M.C). This requirement was included in the Regulations of the British Colonies in West Africa. Before WWII only candidates from the Dominions could be considered. In 1928, when Quebec became a self-governing Province, this concession was revoked.[80] The only European country whose qualifications were registrable with the GMC was Italy. A reciprocal agreement had been signed between the U.K. and Italy in 1925 to regulate the practice of medicine in their respective territories. This was renewed in 1935.[81]

For the African Medical Officers, however, the unification of the CMS in 1934 into a single service did not make any difference. In a circular despatch to the West African governments, it was reiterated that

> it is not proposed that Africans should be appointed to the CMS..... and to prevent misunderstanding Africans employed as medical officers should be given a distinct title.[82]

The official exclusion of African medical officers from the WAMS made it necessary that the former should organise themselves into some sort of body to protect their interest. The first of its kind was the Gold Coast Medical Union, inaugurated late in 1938.[83] In its inaugural ceremony, Dr. F. V. Nanka-Bruce (president) recalled with nostalgia how

> The element of discrimination against the African that has now found so much favour was not known in the old days and it shows how regrettably things have changed for the worse for the African practitioner, to recall that an African once held the post of principal medical officer.....[84]

However, by the time WWII broke out, the Colonial Office was still unable to meet the personnel requirements of the CMS. The only solution to recruitment seemed to be the employment of more African doctors. The number of European medical officers could thus be diminished and their duties confined chiefly to specialist work, teaching, supervision and administration. This view had been echoed by some medical doctors serving in the colonies even before the outbreak of WWII.[85] Indeed, this was a policy that was conscientiously pursued after the war.

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CHAPTER FOUR

THE IMPACT OF WORLD WAR TWO ON RECRUITMENT FOR THE COLONIAL MEDICAL SERVICE IN WEST AFRICA

WAR TIME RECRUITMENT POLICY

Prospects for recruitment for the Colonial Medical Service in West Africa looked bleak indeed in 1939. The problem can best be understood by looking at developments in Britain at the outbreak of hostilities. Before the war most employees (both medical and lay) of the Ministry of Health (MOH) were not permanent civil servants. [1] During the war the Government took over all hospitals in the country and turned doctors and nurses into salaried officials. As a result an element of control was introduced into the use of the services of doctors and nurses. Hence centralization of recruitment.

The Central Emergency Committee, formed during World War One, was reconstituted into the Central Emergency Committee of the BMA in 1937, and it became the Central Medical War Committee at the outbreak of war. It was agreed that the Central Medical War Committee would be the recruiting agency for the supply of medical personnel to the fighting forces and the civil hospitals.[2] The Ministry of Health was responsible for administering the Emergency Medical Services which took care of the civil population; while the War Office was in charge of the medical services of the fighting

forces. As a result most medical men in Britain either enlisted with the Fighting Forces or had contracted with the Ministry of Health. Furthermore, not only was a Conscription Bill enacted but there was also to be a National Registration and any doctors qualifying after that date (1939) were almost certainly to be conscripted for National Service.

In April, 1940, the Ministry of Labour and National Service announced that the National Service (Armed Forces) Act, 1939 would apply to medical practitioners who might be called up for service in any of the forces in their professional capacity. This liability extended to all practitioners subject to the age limit of forty-one.[3] As a result of this ruling many doctors in the Emergency Medical Service were called up. Thus, as the medical strength of the fighting forces expanded it became increasingly difficult to provide medical staff for the civil hospitals. It was in order to remedy and control this development that in 1941, Ernest Brown, who had succeeded Malcolm MacDonald as Minister for Health, announced the setting up of a Medical Personnel (priority) committee. The terms of reference of the committee were as follows:-

> to investigate what further steps can usefully be taken to secure the utmost economy in the employment of medical personnel in H.M. Forces, the Civil Defence Services, the Emergency Hospital Scheme, including the general practice, and having regard to any recommendations made as a result of such investigations to report from time to time what should be the allocation between the above mentioned services of the available medical personnel.[4]

As a result of the recommendations of this Committee an effort was made to meet the essential requirements of the Fighting services and at the same time to safeguard the interest of the civil population.

The implication of this development for the Colonial Medical Service was obvious, as Dr. O'Brien, who had succeeded Thomas Stanton in 1938, as Chief Medical Adviser, lamented:

> In a few weeks we will be unable to recruit any young doctors of the type we require and will be dependent on retired officers for replacements in the Colonial Medical Service.[5]

His fears were soon realised.

Under the circumstances the Colonial Office tried to retain the services of any officers who had accepted appointment but had not proceeded to the colonies. Early in 1939, when the threat of war was looming large, a circular despatch had been sent to all the colonies asking what their requirements would be in the event of war. On the strength of the replies received it was realised that on the outbreak of war, there would be twenty-four unfilled vacancies. Besides, war would cause further vacancies including invaliding, death and transfers to fighting services.

The Colonial Office decided to make special arrangements with the Ministry of Labour for the release of between thirty and forty newly qualified doctors annually to the

A Similar proposal was put to the Deans of the various medical schools requesting them to give publicity on the following lines:

Colonial Medical Service. with the permission of the Ministry of Labour, the Colonial Secretary proposed to select annually a certain number of doctors for appointment to the Colonial Medical Service, and that , as an emergency measure selection would be made in April and May from among students in their last year of study.[6]

In 1939, Malcolm MacDonald, as Colonial Secretary, authorised the recruitment during 1940 of at least thirty doctors who would form a 'pool', take the Diploma in Tropical Medicine and Hygiene and be available for duty in the colonies at any time they were called up. As months passed by it became clear that only men of military age came up for selection. This situation was further aggravated, when, in 1940, the Ministry of Labour changed its policy and decided to exclude doctors from the reserved occupations schedule. The implication was that male doctors within the age groups affected by the National Service (Armed Forces) Act, 1939, were liable to compulsory service in a medical capacity. The regulation, however, stipulated that no doctor would be called up until he had completed six months' professional experience after qualification. This provision ensured that teaching hospitals in Britain would be provided with enough medical staff.[7] For the colonies, however, this change of policy constituted a serious impediment to the proposed policy of creating a 'pool' of doctors for the Colonial Medical Service.

The removal of the medical profession from the schedule of reserved occupations made it necessary for the Colonial Office to search for other avenues of recruitment. The obvious avenue was the War Office. There was no doubt that in war time the Army would need many doctors. The Colonial Office decided to contact the War Office with the hope that the office would be willing to exempt their medical candidates from the three months service with the Royal Army Medical Corps.[8] Contact with the War Office proved unnecessary because most of the candidates selected by the Colonial Office were newly qualified and the Army did not select candidates who had qualified less than six months previously. Other measures therefore had to be adopted because it became increasingly clear that the maintenance of an efficient Colonial Medical Service constituted a vital part of the national war effort. Besides, European staffs of colonial territories had to be assured of an adequate supply of medical personnel.

Sir Wilson Jameson, who had replaced O'Brien in 1940, as Chief Medical Adviser, decided to contact the BMA to discuss the problem.[9] In answer to this he was definitely encouraged to advertise for vacancies. The BMA pledged their support to the recruitment effort by making sure that all Colonial Office candidates would not be taken for military service.[10] Vacancies were advertised in the British Medical Journal and the Lancet. As a result, a few candidates responded but out of the thirty places proposed for the 'pool' there were still about nineteen unfilled at

the end of 1940. Most of those selected were men who had passed military age. Thus little came out of all the efforts made when war broke out to maintain and improve recruitment for the Colonial Medical Services. Throughout the war, therefore, medical recruitment was almost at a standstill.

In 1945, the Colonial Office submitted a memorandum to the Medical Priority Committee regarding the serious shortage of doctors for the Colonial Medical Service.[11] The committee made it clear that the Colonial Office must rely on recruiting demobilised officers to fill outstanding vacancies. That decision was reluctantly accepted but the existing vacancies rose from sixty-four in 1945 to between seventy and eighty in 1946.[12] During the intervening period it had been possible to recruit only twelve medical officers for West Africa. In 1946, the committee was again approached for permission to recruit for West Africa doctors liable to National Service. This concession was granted on condition that doctors recruited in this way would serve for at least two tours of eighteen months each in order to fulfil their obligations under the National Service Act.

The number of doctors who accepted service in West Africa in lieu of service in the Armed Forces was as follows: 1946 (1), 1947 (1), 1948 (2), 1949 (1) and 1950 (2).[13] Thus, in spite of this arrangement the medical recruitment position remained acute in West Africa. In 1947, there were thirty-six notified vacancies, yet during 1948, it was possible to recruit only twenty-two doctors.

By the end of 1948, there were about sixty-two notified vacancies and during 1949 , only sixteen doctors were recruited for West Africa.[14] By 1951 the strength of the medical establishment in Nigeria was 121, 49 in the Gold Coast, 30 in Sierra Leone and six in the Gambia. Most appointments made during and immediately after the war were for short periods, usually for two tours, rather than to the permanent establishment.

Apart from the difficulties experienced in recruiting medical officers for service in West Africa during and immediately after the war, there was the added problem of decline in morale among service officers (both professional and administrative). Firstly, during the war many European officers were required to forgo their usual leave arrangements with the result that prolonged periods of work without a proper holiday affected both health and morale. Secondly, the cost of living had soared as a direct result of the war. Under war conditions salary adjustments were seldom adequate or prompt. Thus in British West Africa pay and conditions of service continued to be a source of discontent. This factor was further compounded by the rapid political changes in some of the territories, particularly, the Gold Coast and Nigeria. The situation created uncertainty as to the future. The war had increased political consciousness amongst the West African public and African political opinion became increasingly vocal.[15]

Although the need to employ expatriate officers was generally accepted, the public began to grudge the cost which was borne by the local tax payer. As early as 1939. West Africa reported:

> African public opinion takes the view that the obvious and most just measure of economy is to replace as many Europeans as possible holding responsible posts in Government service by Africans drawing smaller salaries.....[16]

Attempts to improve the lot of European Officers without due consideration for the locally recruited officers would have been interpreted by the public as a move to perpetuate racial discrimination. Thus when, during the war, individual colonial governors and the West African War Council, in collaboration with the Colonial Office, sought , to improve the pay and conditions of service of European officers they also sought to relate African salaries to those of their European counterparts.

The first attempt to deal with this issue was in 1942, through the individual initiative of Sir Alan Burns, Governor of the Gold Coast. The Governor's scheme provided for the recognition of the principle of equal pay for equal work, allowance for the necessary extra expenses of the expatriate as compared with the officer serving in his home country.[17] Under the scheme, a series of new basic salary scales for all officers serving under the Government was drawn up. The plan was so contrived that an additional 'expatriation pay' of one-third would give the European Officer approximately what he got under the existing scales.

This plan did not see the light of day because it was rejected outright by the Colonial Office. Influenced by the political climate of the time in the colonies, O.G.R. Williams (assistant secretary and head of the West African division) summed up the reason for its rejection thus:-

> Sir Alan Burns' proposals are not likely to be very convincing to the Africans because they involve such a considerable difference between the pay of an African and of an outside appointee and the basic rate plus $33\frac{1}{3}$% addition for expatriation pay are so modelled to ensure that existing European rates of pay shall not be prejudiced.[18]

No doubt, if implemented, the proposal would have resulted in the continued perpetuation of high salary bills of Colonial Governments and the resentment of the indigenes against discrimination in emoluments.

The second attempt at resolving the issue was made in 1944. At the request of Lord Swinton (Resident Minister, West Africa), the Colonial Secretary, Oliver Stanley, sent out Sir Charles Jeffries (permanent under-secretary, C.O.) to investigate the problem and discuss it with the War Council.[19] His directives from the Secretary of State were:-

> to discuss with the Resident minister and the Governors, problems of the relationship between the salaries and conditions of service of locally domiciled and of non-locally domiciled officials and in particular the pressing problem of devising a satisfactory basis for determining salary scales for Africans who will take over duties now performed by superior European staff.[20]

Furthermore, he was specifically instructed to take into account the fact that if the policy of expanding and

developing welfare services in the West African colonies was to succeed, then the African salary scales should not be considered in relation to existing European scales. The fear was obvious. The development and expansion of welfare services called for large increases of staff which would be predominantly African. There was no doubt that if African salaries were related to European salaries progress would be retarded in view of the heavy financial burden that would fall on colonial governments.

Sir Charles held discussions with individual governors, the War Council, and European and African Civil Service Associations. The European Association, as was to be expected, expressed dissatisfaction over pay and conditions of service. In the Gold Coast, they were particularly critical of the Government for, as they expressed it, "doing everything for the Africans and nothing for the Europeans".[21] The African Association, on the other hand, pressed for more access to better paid jobs and reduction in the difference between the relative emoluments of Africans and Europeans.

In view of the objectives of affording wider opportunities for Africans to share in the administration of their territories and of providing the expansion of staff necessary for the effective implementation of development and welfare programmes, Sir Charles proposed a general reorganization of the structure of government staff in West Africa. This plan involved the abolition of the division of

colonial services into European and non-European posts and the establishment of new intermediate grades to be filled largely by local candidates.[22]

The implication of this plan was evident. A reorganization along these lines would have made it practicable to deal with salary scales for the highest classes (to which the bulk of European officials belonged) of appointments on the basis of expatriation pay. The intention of officials in the Colonial Office was clear - appointments to the highest classes in the Colonial Services were to remain an exclusive preserve of the Europeans. This view was succinctly expressed by Charles Jeffries when he put forward his plan for a three-tier system. He said the top tier would consist of principal administrative and professional staffs and would of course be staffed by European Officers. There was to be a third-tier, which would comprise Africans and a second-tier to comprise Africans and Europeans but "the tendency must be for this range [second tier] to be taken over entirely by Africans".[23] While the war lasted, the plan was not implemented, but the Colonial Office and the West African War Council agreed to set up a committee to look into the matter when the war was over.

An enquiry into discontent in the public service in West Africa was authorised in 1945; the Chief Justice of the Gold Coast, Sir Walter Harragin was asked to undertake a review of conditions for all the public services of British West Africa simultaneously. The commission generally agreed that

the discontent in the service was considerable and grievances of government officials, European and African, alike were well founded and should be remedied if morale was to be restored. As regards salary structure, the Harragin Commission's Report recommended the replacement of the old concept of 'African' and 'European' posts by a concept of 'senior'and 'junior' services. For purposes of remuneration officers were regarded either as expatriate or locally recruited officers. A basic salary was prescribed for all appointments and officers who came within the definition of 'an expatriate' were given expatriation pay, equal to one-third of their basic salary. Expatriation pay was pensionable.[24]

Thus the recommendations of the Harragin Commission were no different from Sir Alan Burns' scheme put forward in 1942 and Sir Charles Jeffries' proposals of 1944. As far as salaries and conditions of service were concerned, the Colonial Office was committed to maintaining the status quo. This could only be achieved through the principle of expatriation pay. The main reason why the principle became very appealing was that it had been applied in Palestine and seemed to have worked well[25].

However, as far as European officials in West Africa were concerned, the differential of expatriation pay was insufficient to satisfy them. As usual, the BMA took up the cause of its members in West Africa. Between 1948 and 1949, the BMA made strong representations to the Colonial Office

pointing out that the Association, through its members, had learnt that the increases made by the Harragin Commission were unsatisfactory and inadequate. They further pointed out that under the National Health Service (NHS) doctors of equivalent qualifications and status could earn considerably more in Britain (following the recommendations of the Spens Report) than in the colonies.[26] However, a comparison of the salary scales of European doctors in Nigeria and their counter-parts in Britain, as at 1947, shows that the former were financially at an advantage.[28]

MOH Scale - U.K. (1947)				NIGERIA[26]		
Salary	Pension Provision	Tax	Net	Salary	Tax	Net
1000	50	253	697	1000	20	980
1030	52	266	712	1040	20	1020
1060	53	279	728	1080	20	1060
1090	54	292	744	1120	25	1095
1120	56	305	759	1160	25	1135
1150	57	313	775	1200	30	1170
1180	59	331	790	1200	30	1170
1210	60	344	806	1200	30	1170
1240	62	350	828	1200	30	1170
1270	63	363	844	1200	30	1170
1300	65	376	859	1200	30	1170
1350	67	389	894	1200	30	1170
1400	70	402	928	1200	30	1170
Total net income for 13 years			10,364			14,650

From this table one can see that the average annual income over a thirteen-year period in the U.K. was £800 whereas in Nigeria it was £1,130.

The important thing to note, however, is that the recruitment position was still really bad after the war. The supply of candidates from demobilised services had dwindled. The salary issue was still there and inflation was eating away the gains of the Harragin settlement of 1946. Besides, the Harragin commission had recommended the abolition of private practice for Government medical officers, with the result that some medical officers lost a valuable source of private income.[29] In fact there seemed no practical prospect of filling medical vacancies in West Africa by recruitment from the U.K., in spite of all the efforts made. But, as one official of the Colonial Office observed, "difficulties in recruiting doctors are by no means wholly due to the salaries offered nor are they overcome by offering higher salaries".[30] Indeed, the other factor that became important after the war was job - security. By this time, however, there was a new factor in the recruitment problem - the creation of the National Health Service in Britain.

THE NHS AND RECRUITMENT FOR THE CMS

The idea of a full health and medical service for the whole British population was embodied in William Beveridges famous report of 1942.[31] In 1944, a Bill to create a NHS was presented to the House of Commons by the Conservative Minister for Health, Henry Willink. He declared that its object was

> to fit the nation for its great responsibility, to free it members so far as is humanly possible to free them, from the anxieties, the burdens and the pains of ill-health.[32]

Soon after the return of a Labour government in 1945 a new Bill was presented by Aneurin Bevan; this was enacted in the same year, though it did not come into force until 1948. The NHS Act stipulated that all new entrants to the medical profession would automatically become members of it. To further strengthen this position a Medical Act was passed in 1950. This provided that no newly qualified doctor (as from 1:1:53) would be recruited until after one year's internship at the earliest. Thus, all medical students entered the NHS hospitals on qualifying because of the pre-registration year.[33] The implication was that European appointments for the Colonial Medical Service would only be filled by secondment from the U.K.

Meanwhile, the increasing difficulty experienced in recruiting medical staff for the colonial medical service was causing great concern in the Colonial Office.[34] As mentioned above, in the course of the war the supply of manpower in the CMS, and indeed in the other colonial

services had been progressively weakened.[35] The problem of recruiting for the service became acute, particularly with the adoption of the policy for social and economic development. Thus it became a question, not merely of maintaining pre-war level of services but of planning and executing schemes of improvement embodied in the Ten-Year Development Plans which had been introduced as part of the post-war reconstruction effort. The projected expansion of medical and welfare services called for increased establishments. These included medical officers, nurses and sanitary inspectors.

With the creation of the NHS, however, the Ministry of Health automatically became responsible for obtaining medical recruits from the U.K. for all Colonial Medical Services. To look into the matter and to see to what extent the new development affected the colonies, a meeting was held in the Colonial Office, chaired by Sir Charles Jeffries[36]. Because all doctors concerned had to be found from the NHS the meeting suggested that a coordinated committee of the Ministry of Health and the Colonial Office should be formed. This committee was formed in 1948, under the Chairmanship of Sir Wilson Jameson, the Chief Medical Officer to the MOH.[37] Preliminary discussions between the MOH and the Colonial Office took place in April, 1949, and it was decided to set up a working party "to examine the means by which the employment in the colonies of medical officers from this country can be encouraged.[38]

At this time, the difficulty in recruiting medical staff for the CMS could be explained by the fact, that, for the first time the NHS offered a career for doctors carrying a pension on retirement. Consequently, a pensionable career in the CMS was no longer as attractive as it used to be. Doctors from the U.K. naturally hesitated to give up their pension rights in the NHS in order to join the CMS. It was in order to obviate this difficulty that the working party put forward a scheme for the interchange of doctors between the NHS and the CMS. The scheme put forward was basically to enable doctors in the NHS to serve for short periods in the CMS - periods up to four years inclusive of leave, without any loss of NHS pension rights.

By the time the final proposal was drawn up, a number of checks and balances had been embodied in the proposal to ensure the proper working of the scheme to the benefit of everyone concerned. For example, if doctors recruited under the scheme wished to return to the NHS, the period of their service in the CMS would count for NHS pension. On the other hand, for any doctor who opted to remain in the permanent establishment of the CMS, his pension rights under the NHS would be placed in cold storage during the period of his service, when he would be earning a colonial pension. Furthermore, if a doctor who had been permanently appointed to the CMS transferred or re-transferred to the NHS, his pension, in respect of his service in the CMS, would be payable to him until he retired in pensionable circumstances from the NHS.[40]

An essential feature of the scheme was the proposal for the payment of a gratuity at the conclusion of a doctor's attachment to the CMS in addition to the contributions due under the NHS Superannuation Regulations. The purpose of the gratuity as explained to colonial governments was to assist a doctor to meet the expenses of re-settlement in the U.K.; and secondly to provide a supplement to the NHS Superannuation, in respect of service in a tropical climate.[41] Payment of the gratuity was made on completion of the period of service in the CMS. The rate proposed, i.e. twenty per-cent of the aggregate of Colonial salary, was regarded as representing six per-cent for resettlement and fourteen per cent for Superannuation. Generally speaking the scheme was intended as an alternative to the normal method of recruitment to the permanent and pensionable establishment in the CMS. It was hoped that it would attract recruits who might otherwise hesitate to enter colonial employment at the price of the loss of aggregate pension rights in the U.K.

THE RECRUITMENT OF NURSES

The problem of recruitment was not peculiar to the CMS: the Colonial Nursing Service was also experiencing similar problems. As among the medical doctors, there were two categories among nurses in the medical establishments of the colonial territories: African and European. Upto the outbreak of the Second world war, most fully trained

European nurses for the Colonial Nursing Service were drawn from the U.K. and to a lesser extent from the Dominions. The war had a similar effect on the recruitment of nurses as on the recruitment of medical officers: the British Government opted to exercise greater control over their recruitment and distribution. In the years immediately before the war it had become evident that recruitment to the nursing services in Britain was insufficient to meet the needs of the rapidly expanding health services. As a result, in 1943, the Ministry of Labour and National Service, in consultation with the MOH, set up a National Advisory Council for the recruitment and distribution of nurses and midwives; it was headed by M. S. McCorquodale (M. P., Parliamentary Secretary to the Ministry of Labour and National Service). The object in appointing the Council was to consider the measures to be taken to relieve the shortages of nurses and midwives, which had become acute, owing to the demands of other services.[42] For example, owing to the decrease in the number of available doctors in charge of the civil population, the number of midwives attending births became proportionately higher. In 1940, there were 604,667 live and still births in England and Wales, of which 515,850 were attended by midwives acting as such or as maternity nurses.[43]

Early in 1943 the newly appointed National Advisory Council began its task of advising the Ministry of Labour on the application of controls. One such control was the extension to nurses and midwives of the Control of Engagement Order, which covered women from eighteen to forty

years of age.[44] This meant that nurses and midwives were now required to obtain their employment through an Appointments Office of the Ministry of Labour. For the first time it became possible to prevent those who were available for re-employment from accepting posts which were not considered of urgent importance. Included in this category were posts in the Colonial Service.

The Ministry of Labour made their policy very clear. In a letter to the Overseas Nursing Association, B. A. Bannett (Ministry of Labour and National Service) put it clearly to the Association that the object of this extension of the Control of Engagement Order was to enable the Department to ensure that as nurses and midwives became available, they took up posts where they were most needed.[45] He further pointed out that, as a result of the great need for qualified nursing personnel in Britain, applications by women who wished to take up employment overseas would have to be carefully scrutinised to ensure that candidates required in Britain were not engaged for such posts.[46]

The Colonial Office was naturally concerned about this new development. In the first place, it was supposed to ensure the maintenance of a certain standard of public health service in the colonies, particularly in war conditions if not in peace time. In the second place, it was still a policy of colonial governments that government hospitals should be staffed by senior nurses and midwives recruited from Britain and of British descent. In a letter

to the Ministry of Labour, Oliver Stanley, the Colonial Secretary, requested information as to whether the recruitment of nurses who were required to fill vacancies in the Colonial Nursing Service was affected by the new order.[47] The Colonial Office was accordingly informed that it was now the responsibility of the Ministry of Labour to undertake the advertising of vacancies in the nursing services and it would deal with all applications in the first instance, including those for the Colonial Nursing Service. This was not the only setback. The Colonial Office was further informed that newly qualified midwives would be required to practice for one year in Britain and that practising midwives would not be allowed to take other nursing employments.[48]

In view of this decision, it became evident that neither newly qualified nor practising midwives could be recruited for the CMS. Recruitment of nurses for the CMS was at a standstill throughout the war. In 1943, there were approximately 585 European nursing sisters in government employment throughout the Colonial Empire. Of this number 106 were in British West Africa, 208 in East Africa, 74 in Malaya and 197 elsewhere.[49]

The problem of recruiting nurses for the CMS was further compounded by the creation of the NHS in 1948. Henceforward all nurses and midwives, like medical doctors, were to be recruited for the Colonial Service by secondment from the NHS. The primary object of the scheme as devised for the nurses was to enable them to serve under a colonial

government for temporary periods with no loss of pension rights under the NHS (superannuation) Regulations. The scheme was also devised to preserve continuity for superannuation purposes under the Federated Superannuation Scheme for Nurses and Hospital Officers (FSSNHO). This scheme applied to nurses, who, within twelve months of ceasing employment in superannuable capacity by a Regional Hospital Board or Board of Governors of a teaching Hospital, joined the service of a colonial government.

For superannuation purposes, a nurse was required to continue to participate in the NHS scheme or the FSSNHO. The contributions payable by the employee (six per cent and five per cent respectively), were based on colonial salary exclusive of cost of living allowance. The colonial government by which a nurse was employed was required to pay the employer's share of the contributions: eight per cent of colonial salary in respect of the NHS scheme or ten per cent under the FSSNHO. The amount of contributions payable by the nurse was deducted from her colonial salary.[50]

The scheme was generally similar to that devised for the doctors except in one important respect which related to the gratuity to be paid on reversion to the NHS.[52] If a nurse elected to revert to the NHS on the expiration of her period of duty under a colonial government, she was granted gratuity calculated at fourteen per cent of the aggregate of her salary during her period of service. The purpose of the gratuity was to supplement her superannuation in Britain in

respect of service abroad. Unlike the doctors, nurses were not provided with resettlement expenses. Since most of the nurses who served in the colonies were single, it was considered that a reduced rate of fourteen per cent to cover only the supplement for service abroad was appropriate.

The scheme for the secondment of doctors and nurses from the NHS was hardly implemented when events began to take a different turn in the Colonial Empire, especially in the Gold Coast and Nigeria.

THE POLITICS OF AFRICANIZATION

During the Second World War there was increased pressure on colonial governments to recruit more Africans to senior posts in the public service. Indeed, the difficulty of recruiting Europeans became in itself an incentive to Africanize the service. These pressures came initially from West Africa since not only were the Gold Coast and Nigeria further advanced on the path of constitutional development; they also provided employment for more than a third of the expatriate officers throughout the Colonial Empire.

In the Gold Coast a constitution introduced in 1946 provided for an elected African majority in the Legislative Council, representing both the Gold Coast Colony and Ashanti. However, the Governor still retained 'reserved powers' which he could use in an emergency to override the wishes of the elected majority. Following the riots of 1948

an all - African Commission was set up to devise a new constitution. The Commission recommended a ministerial form of government. On the basis of this recommendation elections were held in 1951 which swept Nkrumah into power.[51]

Meanwhile in Nigeria the Richards constitution had introduced in 1946 the principle of the unofficial majority and laid the basis of the federal system in Nigeria. In 1951, the Macpherson constitution was introduced, which provided for regional governments but retained overall authority for the central government. This constitution proved to be too tightly - knit for a multi-ethnic country such as Nigeria. Consequently a new constitution was worked out in 1953 which gave the regions greater autonomy. By 1954 the regions had advanced to internal self-government.[52]

The rapid constitutional advances in both the Gold Coast and Nigeria after the war were accompanied by a barrage of reports on Africanization. In the Gold Coast, there was in 1950 a select committee of the Legislative Council on Africanization and in 1951 the report of the Lidbury Commission on the Civil Service gave special attention to Africanization.[53]

In Nigeria, the Foot Commission was appointed in 1948 to make recommendations about the recruitment and training of Nigerians for senior posts in government service,[54] and in 1952 Sir Sydney Phillipson and S.O. Adebo headed a commission on the Nigerianization of the service.[55] The

first report on Africanization in Sierra Leone came out in 1949.

The initiative to Africanize government service in British West Africa after the war came from Sir Alan Burns. His commitment to the policy of Africanization made him one of the most liberal and progressive colonial governors of his time.[56] From 1942 when he became governor of the Gold Coast, he made it a fundamental policy of his government to appoint suitable Africans to senior posts wherever they could be found. In a confidential minute to the senior members of his service, a copy of which was sent to the Colonial Office, Burns emphasised that "the steady Africanization of the public service is the settled policy of this Government".[57] To those who were not prepared to accept its implications he warned that they should consider seriously whether they can conscientiously continue to serve a government with whose policy they are in fundamental disagreement.[58] Burns' progressive policy led to the appointment of two Africans (K. A. Busia and A. L. Adu) to senior posts in the administrative service.[59]

All the same, it was obvious that there were not enough qualified Africans for appointment into senior posts in the public service, not only of the Gold Coast but of other British West African territories. This meant that expatriate officers would still be needed to fill vacant posts. The Gold Coast Government suggested a slackening of the regulation which stipulated that only medical officers

with British qualifications and who were of British descent were qualified to practice in West Africa.[60] In May, 1950, Sir Alan Burns addressed a letter to Lord Lloyd, in which he suggested that the Colonial Office should follow the example of the Australian Administration in New Guinea by employing more doctors from continental Europe.[61] In response to this, Sir Wilson Rae, then Chief Medical Adviser, said, "I would rather see some stations closed than reduce standards in any way".[62] However, with the rapid political advancement in the territory the policy was revised. In 1951 the Gold Coast government amended the Medical Practitioners and Dentists Legislation Ordinance, to enlarge the category of persons eligible to practise as doctors and dentists: people who might be so licensed could now include those entitled to practice medicine and dentistry by the law of Countries other than the U.K.[63] Moreover, by 1953, the Gold Coast Government had asked the Colonial Office to cease all recruitment on pensionable terms and to cease the transfer of pensionable officers to the Gold Coast.[64] Recruitment of expatriate officers thereafter was on contract basis.

The shortage of trained and educated personnel was recognised by the Foot Commission in Nigeria in 1948. The commission observed that the training and recruitment of Nigerians for senior posts in government service was not only necessary to enable Nigerians to take an increasing share in the management of their own affairs and to allow the service to keep in step with the pace of constitutional advance: it was also essential for the development and

progress of the country. Among the principal recommendations of the commission were (1) no expatriate should be recruited for any government post except where no suitable and qualified Nigerian was available (2) Public Service Boards with non-official majorities should be appointed to select candidates for senior posts and for scholarships and training schemes.

Although the emphasis was on scholarships and training schemes, the recommendations were expressly provisional and short-term in character. The Commission's recommendations regarding scholarships and training schemes related to a period of three years.[66] Between 1945 and 1948 the following number of Nigerian students were studying either medicine or nursing in the U.K.[67]

	1945-46	1946-47	1947-48
Medicine	77	84	105
Nursing	1	17	48

Between 1948 and 1952, eighty-one medical scholarships were awarded by the Nigerian government and thirteen in General Nursing and Midwifery. In 1952, there were fifteen government medical scholars and 156 private students in the U.K. alone, as well as 258 (both government scholars and private) nursing and midwifery students.[68]

An interesting omission from the Foot Commission Report was that no recommendation was made regarding the regulation of expatriate recruitment in proportion to the prospective Nigerian supply by means of contract appointments. This was what the Phillipson and Adebo commission set out to correct in 1952. However, while the commission was still sitting, it became obvious that the unqualified application of the policy of Nigerianization was unacceptable to the Northern Region in view of the relative shortage of qualified Nigerians of northern origin.[69] The main reason was the fear of domination by the South. In March, 1953, Inuo Wada Kano, a member of the House of Representatives, publicly declared this fear. He said,

> We are not hiding it..... To us [Northerners] Nigerianization means Southernization. You come into our Office in the North, into the Secretariat or anywhere, what do you see? You do not see Northerners. You see our brothers from the East and the West.[70]

As a result of this fear, the North expressed the desire that they should be allowed to continue to employ expatriate officers in the higher posts until such a time that suitable Northern Nigerians became available. They also demanded the Regionalization of the public service. These suggestions, if adopted, would have brought issues such as appointments, promotions, transfer and discipline directly under the control of regional governments. Although the constitution of Nigeria as it operated in 1953 was marked by strong central features, the commission did not overlook the problem as it concerned the North.

In its report published in 1953, the commission recommended among other things that, "to the maximum extent possible the future recruitment of non-Nigerians shall be on a contract basis regulated to fit in with anticipated availability of qualified Nigerians".[71]

The commission also pointed out the need to take into consideration the paucity of qualified northerners for senior posts and the desire of the northern leaders to keep the higher ranks of the service in that region open for persons of northern origin as they became available. They therefore recommended that preference should be given to qualified candidates of northern origin over all other candidates.[72] On the establishment of Regional Public Service Commissions, however, the commission noted that, "The time is not ripe for the creation of Regional Public Service Commissions in addition to a Central Public Service Commission".[73] As a result the commission advocated the establishment of a Central Public Service Commission with regional branches to deal with appointments, recruitment, promotions and discipline within the service.

The Phillipson and Adebo Report was overtaken by political events in Nigeria of 1953 and so could not be implemented.[74] A new constitution was drafted in 1953 which gave the regions greater autonomy than they had possessed under the previous constitution. The 1953 constitution removed the powers of intervention by the central government in matters which were placed within regional competence.

The new constitution established a true federal structure of government for Nigeria. It came into operation in January, 1954, and by that date also the territory achieved internal self-government. Under the new constitution the public service was split into four separate services: The federal public service and the public services of the three regional governments. A Federal Public Service Commission was set up as well as three Regional Public Service Commissions.

As a result, it became necessary to set up a commission to enquire into the structure and renumeration of the Public Service and to examine the problems from the individual aspect of the future Federal and Regional Governments. The Gorsuch commission on the public services of the Governments in the Federation of Nigeria was appointed in 1954 to look into these issues.[75] Its Report recommended that although the policy of recruitment was Nigerianization, in each region preference was to be given to candidates born or domiciled in the region. In respect of serving officers, in none of the four services should discrimination be shown against a serving officer of external origin, whether Nigerian (from another region) or overseas.[76]

The position of overseas officers also needed to be clarified under the new arrangement. With regard to them it was laid down that:

> Overseas pensionable officers transferred to a Regional Service would retain their status as members of the Colonial Service, including their existing eligibility for consideration for transfer or promotion to Colonial Service posts in other Territories. Arrangements would also be devised to enable officers who so desired to be considered for transfer and promotion to other Nigerian Public Services than that to which they may immediately belong.[77]

The commission also recognized the continuing need for overseas officers. It noted that the University College of Ibadan established in 1948 could not meet the need of Nigeria for political, economic and social development. They recommended that inducements were necessary to attract overseas recruitment. As a result, they suggested that the term 'expatriation pay' should be replaced by 'inducement addition'. It was stressed however, that the receipt of inducement should not confer on the recipient any superiority of grade. Status and seniority should be determined by basic salary.[78] In 1957 the government ordered that the recruitment of expatriate officers on pensionable terms should cease except in rare and very special circumstances.[79] The abolition of pensionable service and the attainment of self-government by the British West African colonies between 1957 and 1961 resulted in a falling off of expatriate recruitment.

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2. C. L. Dunn The History of the Second World War: The Emergency Medical Services Vol. I (London, 1952), p.21.

3. Ibid. P. 390.

4. Quoted in Ibid. p. 394.

5. Minutes by Dr. O'Brien dated 5/9/39 in CO877/19/27215/21 (1939) Medical vacancies: Wartime recruitment policy.

6. CO877/19/27215/21 (1939), op. cit. By 1940, this arrangement became moribund because in that year, doctors were excluded from the reserved Occupational Schedule. This meant that they became governed by the Armed Forces Act of 1939.

7. See for example C. L. Dunn. Op. cit.

8. CO877/19/27215/21 (1939), op. cit.

9. Letter by Sir W. Jameson, dated 30/5/40 to BMA in Ibid.

10. G. Anderson (Secretary, Central Medical War Committee) to Sir W. Jameson, dated 4/6/40 in Ibid. It should also be added here, that, the BMA exercised a certain amount of control over newly qualified men through membership of various war committees.

11. "Colonial Office Memorandum for Submission to the Medical Priority Committee" in CO877/27/3/272/5/35 (1951) MOH - Central Medical War Committee - Correspondence regarding Medical Officers applying and selected for the CMS.

12. Ibid.

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15. See e.g. G.O. Olusanya, The Second World War and Politics in Nigeria, 1939 -1953 (Lagos, 1973).

16. West Africa (June 17, 1939), p. 803.

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37. CO877/37/5/272/5/206/1 (1949-50) Committee to advise on recruitment for overseas medical service.

38. FO. 1015/172/20/23 (1949) Report of working Party; Interchange of doctors between the NHS and the CMS.

39. Ibid.

40. These proposals were explained to Colonial Governments in circular despatch, 8/10/1949, Creech Jones to Colonial Governors in CO877/37/5/27215/206/1 (1949-50).

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45. B. A. Bannett to Miss Gawan Tylor (Secretary ONA) dated 12/10/43 in CO850/192/20580/8 (1943) Colonial Nursing Service: Wartime Recruitment

46. Ibid.

47. Oliver Stanley to Ministry of Labour, 12/11/43, in Ibid.

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50. Scheme for the employment of nurses from the NHS in the Colonial Nursing Service encl. in Circular dated 2/3/51 (James Griffiths, Colonial Secretary to colonial governments), in CO850/253/2/21014/29 (1951) CNS: Appointment of nurses from the NHS.

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56. See for example R. Rathbone "The Government of the Gold Coast after the Second World War" African Affairs, ixvii (1968), pp. 209-218.

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62. Minute by Wilson Rae dated 21/6/50 in Ibid.

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64. Sir C. Arden-Clarke (Governor) to C. O. dated 27/5/53 in CO1017/265 (1953) Suspension of recruitment of overseas officers to the Gold Coast.

65. Foot Commission, op. cit.

66. Ibid. paras. 24 - 32.

67. Ibid. p. 14

68. Figures compiled from Appendix IX, P. 117, The phillipson and Adebo Report, op. cit.

69. The Foot Report Observed that the Situation in the Northern Provinces was a particularly serious one because the number of persons qualified to enter a University, was unlikely to reach more than 30 a year for some time to come.

70. Nigeria: House of Representatives Debates, Second Session, Vol. 11 March, 1953, pp. 471-473.

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73. Ibid.

74. On the politics of Regionalism in Nigeria and their effect on public service of the country see for example, G. O. Olusanya the Evolution of the Nigerian Civil Service 1861-1960 (Lagos, 1975).

75. Report of the Commission on the Public Services of the Governments in the Federation of Nigeria, 1954-55, (hereafter cited as Gorsuch Report).

76. Ibid.

77. Gorsuch Report, p. 28.

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CHAPTER FIVE

POST-WAR DEVELOPMENT AND PLANNING FOR MEDICAL AND HEALTH SERVICES IN BRITISH WEST AFRICA

INTRODUCTION

The medical services in British West Africa and elsewhere in tropical Africa had a common origin in the desire to look after government officials. Each Director of Medical Services (DMS), most of whom were biased towards curative work, bent development in the direction he favoured. Thus medical policy in the colonies was ad hoc and based on expediency. The only common pattern which seemed to have emerged by the Second World War was a series of hospitals and dispensaries, simple or elaborate in construction, depending on their location.

Concentration on curative work was apparently due largely to policy being based on the satisfaction of the most obvious demands on the medical staff, without full consideration being given to the problem of the medical needs of each territory as a whole. The situation was further complicated by the lack of resources, both human and financial of the colonial territories. During the second world war the emphasis on preventive medicine gradually developed. No longer was it sufficient to make the sick well; the aim became the promotion of good health and the elimination of preventable diseases. This goal could only be achieved if adequate staff was provided and adequate

funds made available to carry out the necessary measures. The new approach to colonial medical and health problems can best be understood in the wider context, not only of colonial development and welfare, but also of post-war planning and reconstruction.

INITIATION OF A FORWARD POLICY

By the late 1930s it had become increasingly clear that the development of both the economic and human resources of the colonies could not be undertaken without substantial assistance from the imperial government.[1] During this period several reports and publications helped to change the climate of opinion. First, Lord Hailey's African Survey, published in 1938, indicated a need for a more positive financial and technical assistance for the colonies.[2] Secondly, the Report on Nutrition in the Colonial Empire, published in 1939, showed the low standard of living that was generally prevalent in the colonies.[3] Thirdly, a series of distressing reports on conditions in the West Indies led to the appointment in 1938 of a Royal Commission under the chairmanship of Lord Moyne to investigate the problems of that area. The commission reported in the following year but the report itself was not published until 1945.[4] The report revealed appalling social and economic conditions which could only be remedied by substantial assistance from outside. According to Sir Charles Jeffries "<T> these documents provided the chief evidence which made it possible for the secretary of state, Malcolm MacDonald to institute

the proceedings leading to the passage in 1940 of the Colonial Development and Welfare Act." [5]

Whereas the 1929 Act had been directed towards material development, the new Act gave expression to the notion of welfare. The new emphasis on the development of the social services was a welcome innovation for some colonial governors, such as Bernard Bourdillon (Governor of Nigeria, 1935-43), who in the late 1930s and early 1940s had urged the Colonial Office to assist financially in the social development of the colonies. His intention was for metropolitan subsidies to be granted to colonial territories for the development of health and educational services. [6]

In spite of the military situation in Europe the Act was given royal assent and became law on 17 July, 1940.[7] Financial assistance to colonial governments up to a maximum of £5 millions a year for ten years was proposed. Assistance was to be provided not only for schemes involving capital expenditure but also for helping to meet recurrent expenditure on certain services designed to improve economic and social conditions.

The Colonial Development and Welfare Act was welcomed both in Britain and in the colonies. Leo Amery, a one-time Colonial Secretary (Nov. 1924- June, 1929), wrote personally to congratulate Malcolm MacDonald on his bold departure in Colonial policy. He added, "you are not only right in the policy itself but also in having the courage to launch it at

the present moment".[8] From the Gold Coast, J.B. Danquah, on behalf of The Gold Coast Youth Conference, hoped that the new policy would be

> beneficially used in the interests of the peoples of the Colonial Empire in general and the Gold Coast in particular to provide means of creating much needed employment for the masses of the Gold Coast youths.[9]

Similarly, the Nigerian Legislative Council welcomed the generous gesture of the imperial government particularly as it was made in times of national stress but hoped that the new policy would not involve a derogation of the rights and privileges of the local legislature. [10]

The C D & WA was placed on the statute book at a grave time in British history. Its enactment was designed to be taken as a deliberate assertion of a reformed colonial policy. It was however recognised that the application of the Act and of colonial social reform in general would have to await more favourable times. The new Colonial Secretary, Lord Lloyd, in an address to the Conference of Missionary Societies in June, 1940, declared with reference to the effect on Africa of Italy's declaration of war:

> It is useless to pretend that at present we can carry on as usual with the normal social services of government, meagre though some of them are; still less is there at present a chance of making much progress with our plans on colonial development.[11]

The problem at the time was primarily a matter of material and personnel. Materials such as steel simply could not be made available other than for war purposes,

while a large number of government personnel had to take up military duties.[12] Nevertheless, Lord Lloyd went on to say that, "it is as we all realise vitally important that the interruption of Social Services should be kept to the minimum".[13] In this connection he drew attention to the possibility of a more economic use of staff by the training of Africans and to wider cooperation with missionary societies. In a circular despatch to all colonial governments, the economic and social consequences of the intensified war were stressed.[14]

It was clear that under war conditions it would not be possible to make any substantial progress under the new policy. As a result, assistance was promised only for urgent purposes and for schemes which could be carried out from local resources of personnel and materials without detriment to the war effort. Thus the new conditions entailed not only postponement of progress but also curtailment of existing social and other services.

In spite of this obvious setback, however, a sub-committee consisting of Sir Alan Burns (a beachcomber)[15], G. L. M. Clauson and Sydney Caine was appointed to look into the question of drawing up some simple headings for development programmes which could be issued to colonial governments. The Sub-Committee recommended the following headings under public health: administration of public health and medical services, training of personnel, health units (including public health propaganda), hospitals, laboratories, special problems in relation to the prevention

and control of diseases and nutrition.[16] The main object of this list was, as Lloyd explained,

> "to facilitate the examination in the C.O -of the programmewas which will be submitted to me by colonial Governments and the consideration of the application for assistance form U.K. funds which will be made with them?.[17]

The emphasis here was on the role of the Colonial Office in the new C D and W Act: the Treasury had attached great importance to the Colonial Office taking direct responsibility for development schemes.[18]

From about 1940, the Colonial Office began to prepare for definite post-war policies. Details had to be decided upon so that after the war there would be no delay in implementing them. In Britain a number of inter-departmental committees were set up to effect the transition from war to peace. In March, 1941, Lord Moyne, who had succeeded Lord Lloyd as Colonial Secretary, appointed a Colonial Office committee on post-war problems with Lord Hailey as Chairman. The Committee mainly consisted of assistant secretaries (Dawe, Pedler, Battershill, Jefferies and Clauson).[19] The Committee had no precise terms of reference. Indeed, it was not until April, 1942, that a schedule of subjects for consideration under public health was drawn up. The emphasis was on mass attack on preventable diseases and the prosecution of measures for improving the health of the largest numbers of people.[20] In 1942, planning for post-war development took a step forward with the drafting of a Colonial Medical Policy by the

Colonial Advisory Medical Committee (CAMC). Never before had there been an attempt to plan in any way the future of medical and health development in the colonial territories.

THE CAMC AND THE FORMULATION OF A MEDICAL POLICY FOR THE COLONIAL EMPIRE

Before the outbreak of WWII the CAMC did little more than receive and comment on the Annual Reports of the Medical Department of the Colonies. Under war conditions these reports arrived very irregularly and had become very much abbreviated. As a result, during their meeting of 6th May, 1941, the committee decided that for the duration of the war they should convene only as the occasion demanded to advise on matters of medical policy arising in the colonies.[21] This attitude provoked a Colonial Office official to remark:

> I cannot recall any instance of the office <C.O> seeking its <CAMC> advice on matters of general medical or health policy; and it certainly never initiated suggestions off its own bat.[22]

However, the character of the committee took a turn for the better in 1942.

The CAMC meeting of 24 June, 1941, was attended by Lord Lloyd, who had taken over from Malcolm MacDonald in May, 1941, as Colonial Secretary. He expressed the hope that the committee would find wider scope for its activities in the future owing to the expansion of the policy of colonial development and welfare.[23] The implication of this was

that the Colonial Office suddenly became aware that they had not made adequate use of this very high-powered and professional body. Thus in 1942 the committee considered that the time was opportune to place on record a broad statement of the basic principles which, in their view, should govern colonial policy in the medical field. Such a statement was necessary in order to ensure that the greatest possible benefits were obtained from the funds available and that medical programmes in the colonies were planned with wider outlook.

In 1942, the committee had the following membership Harold Macmillan (parliamentary under-secretary of state for the colonies, Chairman); A.G.H. Smart (Chief Medical Adviser, C.O; Vice-Chairman); Wilson Jameson (Chief Medical Officer, MOH); Mary Blacklock (Liverpool School of Tropical Medicine), Edward Mellanby (Medical Research Council); Philip Manson-Bahr (London School of Hygiene and Tropical Medicine), C.C. Chesterman (Medical Missions), W. E. Glover (British Medical Association); and Charles Jeffries, J.J Paskin and R. B. Gray, representing the Colonial Office. [24]

The committee stressed the importance of medical and health facilities in the chain of services whose function it was to look after the welfare of the general population. The committee further recognised that while specific problems of public health varied in the different territories the fundamental needs remained the same. Policy should be aimed at securing the benefits of modern medicine

to the largest number of the population possible. To this end all relevant agencies should be employed, given that medical problems could not be divorced from socio-economic problems.

In designing their policy the Advisory Committee, emphasised the concept of the medical service as a community service. To them, "the medical service should be conceived as part of a corperate effort for improving the welfare of the community."[25] For the policy to be successful it was recognized that all bodies -official and unofficial - which were competent to assist, must play their part. As a corollary to this plan of coordinated development, the preventive aspect of medicine was emphasised. The Committee, while fully recognizing the need to cure and alleviate diseases as well as the essential value of hospitals in meeting this need and securing the confidence of the people, formed the impression that, in some territories too much stress was placed on curative services rather than on the maintenance of good health. There was no doubt that the patients admitted to hospitals constituted a small proportion of the people who suffered from disease and its effects and that many of them would not have been ill had their social environment been better. The committee therefore felt that it was the primary duty of the medical establishments to help in the maintenance of good health and to eliminate preventable diseases wherever possible by controlling the transmission of diseases.[26] Indeed, it was only through a policy such as this, that medical and health facilities could be extended to the rural areas.

The committee further recognized that for such a policy to be successful, there should be large increases in the medical establishments - both in the senior and in the auxillary ranks. These increases could only be achieved through the training and employment of more Africans. According to the Advisory Committee, "The proportion of Euro-recruited members of the establishment of colonial medical departments must, as time goes on, decrease and the proportion of locally born and recruited personnel must increase." [27]

The statement of policy was published in January, 1943, by the Colonial Office and was adopted in principle as the basic plan according to which colonial medical services should develop.[28] The C.O agreed with the Advisory Committee that the curative approach to the problems of disease in the tropics was unsatisfactory and that better results could be obtained by an expansion of preventive medical services. In March, 1943, the published memorandum was circulated to all colonial governments for comments.

Two major issues of policy were addressed in the memorandum on medical policy. The proposal to extend medical services to the general population raised the question of whether medical services in the colonies should be provided by the state, by private practitioners or by both. The proposal for a state medical service could be said to be a reflection of the prevailing climate of opinion of the time in Britain concerning the provision of social

services. Some of the prevailing ideas were embodied in the Beveridge Report of 1942 which argued the need for a National Health Service which would enable everyone to obtain free medical treatment.[29] The second major issue addressed by the memorandum was reflected in its recommendation that indigenous medical personnel should gradually be absorbed into all ranks of the medical establishment.[30] This recommendation was rigorously followed after the war.

There were several reactions to the statement of policy from the colonial governments. From Nigeria, the general opinion of both Dr. Harkness (DMS) and Dr. Walker (Deputy Director) was that the expansion of medical services without replacement by local personnel should be the policy in Nigeria for a good many years. Dr. Harkness considered that, 'the time when medical duties will be taken over by locally recruited staff from those engaged in the U.K. is so far off that its contingencies need not for the moment be given the degree of emphasis accorded to them by the committee.[31] However, there was one point of consensus. Dr. Harkness, like the CAMC, agreed that prevention rather than cure should be the aim; and that greater emphasis should be laid on the importance of environmental hygiene in the prevention of disease.[32]

By far the greatest bone of contention was the twin issue of a State Medical Service and private practice. In a section of the memorandum headed 'Duties of a Medical Officer' the Advisory Committee declared:

> the ideal to aim at is a state of affairs in which Government Medical Officers are wholly employed upon Government work and private practice is undertaken by private practioners..... The committee consider that private practice [by Government Medical Officers] should be discouraged and wherever practicable abolished. [33]

Hitherto, all officers of the WAMS, except the DMS, the MOH, Senior Medical Officer, Gambia, and the Deputy Directors of medical services were allowed to take private practice provided that it did not interfere with the efficient performance of their official duties. Indeed, the privilege of private practice by members of the WAMS was supposed to be a major attraction of the service. In the exercise of their private practice, however, medical officers were entitled to the use of government instruments and appliances. In the early years, the issue was treated almost entirely as a matter affecting Government Medical Officers in their relations with the commercial community and those African who could afford to pay private practitioners.[34] The approach was naturally governed by the contemporary view of the functions of a medical service - the diagnosis and treatment of disease. The conception of a medical service as an instrument for effecting improvement in the physical and mental health of the people had not at that time taken root. As a wider conception of the duties of a medical service to the community developed it became apparent that in most colonial territories where the bulk of

the people could not afford to pay private practitioners, the state must take some action. But the ability of the state to take more positive action depended on its resources.

Hilary Blood, Governor of the Gambia, took it upon himself to raise these issues with the C.O . He took the initiative precisely because the Gambia, being a poor territory, was in no financial position to provide a state medical service for its people. Thus the initial response by this governor to the statement of policy was hostile if not indeed aggressive. In April, 1943, he wrote to Oliver Stanley, the Colonial Secretary:-

> in the Gambia ..... we find there is a great gulf fixed between telling us what we are to do and providing us with the means to carry out our instructions.[33]

In June Blood asked the Colonial Office whether it should be assumed that medical and health services were to be extended throughout the colonies on the basis of a government medical service.[36] In autumn 1943, Oliver Stanley visited British territories in West Africa and he was presented in the Gold Coast with a petition by the Joint Provincial Council of Eastern, Central and Western Provinces: this demanded the extension of medical and health facilities and the abolition of private practice. The Council claimed that the services of government medical officers were not being evenly distributed and medical officers employed in the public services were permitted to carry on private practice with public medicines, public time, and public appliances and in

addition charged professional fees from patients treated by them in public hospitals.[37]

As a result of the war the Colonial Office thought it better to leave the matter in cold storage because according to W. H. K. Campbell, "This was a very large question which I do not feel can be dealt with quickly."[38] But Hilary Blood persisted: "the increasing interest which is being taken in Social Security throughout the colonial Empire makes it necessary that the policy should be settled soon".[39] The Colonial Office decided to refer the matter back to the CAMC but a decision was taken only after the war had ended. On the advice of the Advisory Committee, the Secretary of State despatched a letter in January, 1946, which advised that government medical officers should withdraw from private practice. The West African Governors Conference, which met in Lagos in April, 1946, agreed to refer the matter to the Harragin Commission on Salaries which was then sitting. The Commission recommended the abolition of private practice by all government medical officers and the payment of compensation to officers who lost this privilege. [40]

By the end of the war the idea of a state medical service was generally accepted in Nigeria and the Gold Coast. However, the achievement of this object on the scale proposed for Great Britain after the war was not practicable for several reasons. First, in the colonial territories, heavy capital expenditure and a great

expansion of staff would be necessary in order to bring existing facilities to a proper standard. Secondly, the cost of a state medical service similar to that in the U.K. would be relatively much higher. [41] Thirdly, it would have been quite impossible to recruit sufficient doctors to meet the requirements of all the colonies. In spite of these limitations, however, it was clear that the ultimate aim should be a full state medical service, and the first step towards achieving this was identified as the abolition of private practice by government medical officers.

If a full state medical service was to be regarded as the final object of medical policy, it followed that any plans for the development of medical and health services should envisage a gradual expansion of government activity in this field. The colonial governments in British West Africa attempted to achieve this goal in three different ways: training of medical personnel, extension of both curative and prevention facilities and greater cooperation with voluntary agencies. This approach was reflected in their development plans.

THE MACHINERY FOR IMPLEMENTING DEVELOPMENT POLICY

The 1940 Act emphasised the need for the Colonial Office to create an appropriate machinery that would coordinate development programmes; the need for regular liaison between officials in the Colonial Office with those in the colonial territories; and the need for planned development and welfare. With the first aim in view, a Development

Department was established in the Colonial Office in 1940, to deal with the financial and administrative problems of the new Act.[42] Also during the war, it became more usual for Colonial Office Officials and technical advisers to visit the colonies. The whole idea was one of collaboration between officials in the colonies with those in London. To further strengthen the liaison a Development Adviser (W.H.K Campbell) was appointed for West Africa in 1943. His functions were purely advisory[43]. He was attached to the office of the Resident Minister in Accra.[44]

In the colonies, the need to develop similar machinery to coordinate development amongst the various departments was emphasised in Oliver Stanley's circular despatch to colonial governments in August, 1943. [45] In response to this an Advisory Committee on Economic Development and Social Welfare was established in Nigeria under the Chairmanship of the Chief Secretary. The Secretary of the Committee was in charge of a special section of the Secretariat which dealt with development and welfare problems.[46] In the Gold Coast a central planning committee was established; it was divided into a Welfare committee and an Economic Development Committee.[47] In Sierra Leone a Central Committee was appointed with two Regional Committees - one for the colony and the other for the Protectorate. An officer was charged with special planning duties in the Secretariat.[48] Similarly, in the Gambia, where by 1943, parts of the development plan had been drawn up, a committee was appointed under the Colonial Secretary (equivalent to

the Chief Secretary) to supervise the implementation of the plan and revise it from time to time. [49]

Although much progress had been made in the organization of medical and public health services in the colonies, no formulated plan had hitherto been laid down. Progress had depended on fluctuations in revenue and changes in personnel. One of the changes introduced in the 1940 Act was the requirement that development plans should be prepared so that individual schemes could be seen in relation to the whole plan of development and welfare. This useful innovation avoided the piecemeal approach to the 1929 Act.

The first major development plans for most of the colonies in British West Africa were prepared after the war for ten-year periods. To assist in drawing up the plans, Development Officers were appointed in all the territories. They were intended to supplement the man-power resources of the administrative and other regular services. They worked under the orders of Residents or District Officers. They were required to perform one or more of the following functions:-

a) to relieve administrative or technical officers of some of their routine duties in order to free them for work in connection with the planning and execution of development schemes.

b) to undertake subordinate office or field work in connection with the local planning and execution of development schemes.

c) to supervise in the field the execution of development schemes under the general direction of the local administrative or technical officers. Such supervisory work might include the supervision of road construction water development or rural housing improvement schemes or even schemes in the medical and agricultural fields.

d) to train African staff to take over the duties of Development officers in due course. [50]

DEVELOPMENT PLANS

Medical Services in British West Africa before and during the war were highly defective in terms of the 1942 policy which aimed at providing medical attention for the whole population. Medical Services were grossly inadequate. Those living in remote areas received no treatment at all. Little or no liaison existed between private practitioners and the Government hospitals and in turn between the latter and the missions and other similar organizations. These defects were obvious to any new arrival to West Africa. In 1942, J.B. Kirk - the newly appointed DMS to the Gold Coast observed the disparity which existed in the provision of medical and health facilities as between the Colony and the Protectorate. With regard to the Northern Territory of the Gold Coast, he remarked:

> the only direction in which I could find evidence that the Central Government have made any attempt to ameliorate the condition under which the people conducted their every day affairs has been in the provision of certain water supplies, but even here experience has not been entirely happy...[51]

Similarly, Gerald Creasy (a visiting official of the C.O.), during his visit to West Africa, between November, 1943, and January, 1944, observed, "it did not appear to me that any great progress had been made with either medical or agricultural work since 1935".[52] Also, F. E. V. Smith (Development Adviser, Nigeria), observed that the first thing that became apparent in Nigeria was the appalling condition in which the majority of the people lived. In the Northern Provinces of the Territory for example, "for six or eight months of the year many people had to make a journey of several miles in order to obtain a gallon of water which had to serve the needs of a whole family for one day".[53] It became obvious therefore that the fundamental necessity was not so much development as welfare: spectacular development could not be looked for until the basic necessities of life had been provided. The development plans recognised these anomalies and set out to correct them. Even so, the practicability of planning varied enormously from territory to territory.

Each colonial government drafted its own programme. The Colonial Office, recognising that because of staff shortages some colonies might not be able to draw up whole programmes, allowed them to send in applications for individual schemes

or sections of a programme. A number of the early drafts of development plans were little more than departmental estimates. However, the plans that were eventually adopted evolved from discussions between the authorities in London and the respective colonial governments.

The Nigerian Government, because of their financial situation, could not draw up their development plan until the war was nearly over. Indeed, Nigeria had hardly recovered from the effects of the depression of the early 1930s when war broke out. It was only until the middle of the war that the economy began to show signs of recovery as the table below shows:[54]

Year	Revenue	Expenditure
1939-40	6,113,126	6,498,566
1940-41	7,273,157	7,254,325
1941-42	7,975,054	7,026,894
1942-43	9,034,000	8,999,000
1943-44	10,913,000	9,977,000
1944-45	11,445,000	10,133,000

Even so, the long term effects of the depression were enormous as one scholar has recently put it, "the net effect of this situation was that nearly all government departments concerned with the provision of social and economic services marked time for a decade..."[55]

The Nigerian government began drawing up a complete development plan in 1944 and by 1945 had presented it to the

Legislative Council. The plan was adopted in 1946. The Original Ten Year Development and Welfare Plan gave highest priority to water supplies and health; education came next, followed by communications, the economic department and lastly, the coordinated departments, including statistics and social welfare.[56] Its medical and health section, prepared by J.W.P. Harkness (DMS), regarded Nigerian conditions as below the average in the Colonial Empire.[57] The medical plan was designed to form a modest framework capable of maintenance by local finances and of being expanded. It was largely confined to staff training the expansion of hospital and dispensary services and the provision of field units.

On the curative side, the plan called for the extension of hospital and dispensary services on the lines of one or two first class hospitals in each Province so as to provide one bed per 2,000 of the population by the end of the ten years. These would be supplemented by smaller hospitals in the districts, rural health centres and dispensaries. The plan also called for the building of one new hospital, the extension and modernization of twelve others, the provision of eight new secondary hospitals and the provision of fifty-eight new hospitals of the smallest size and the improvement and modernization of nineteen others.[58] Thus, Nigeria in 1946, with a population of over twenty-one million, would have thirteen class 'A' hospitals, nineteen Class 'B' and eighty class 'C' hospitals, providing about 4,275 beds by 1956.[59] These figures include those provided by private

agencies. The cost of the construction of these hospitals was estimated at £2,483,000, together with £496,000 for equipment and £139,000 for the provision of ambulance services. The cost of the maintenance including staff, for these hospitals over the ten years was estimated at £1,687,000.[60]

In connection with the mass treatment of epidemic and endemic diseases, particularly smallpox, yaws, cerebro-spinal meningitis, eighteen mobile units were to be set up. These would deal with any serious outbreaks of infections diseases and at other times carry out a progressive plan of vaccination and general rural health improvement. The functions of a Medical field unit in Nigeria have been described as follows:-

> Composed of a medical officer, sanitary superintendent and at least 25 orderlies, the medical field unit is designed for operation in general public health in a way comparable to sleeping sickness teams. It is an instrument for rapid control work in epidemics and for organizing on a field scale the investigation, treatment and control of endemic diseases and states of subnormal health.[61]

It was hoped that the medical field units would help to control both epidemic and endemic diseases in the rural areas.

To further promote preventive medicine and extend health care facilities to the rural areas, twenty-one Rural Health Centres would be established to consolidate the work of reduction of diseases effected by mass treatment. Each Rural Health Centre would supervise a circle of improved

Native Authorities dispensaries. Provision was also made for the extension of maternity hospitals in six major important towns as well as wards for this purpose at each of the general hospitals. Facilities for the training of medical officers, pharmacists, nurses, midwives, health visitors and sanitary inspectors were provided for. There was also provision for the establishment of tuberculosis, dental, ophthalmic and mental health services.

The Colonial Development and Welfare Advisory Committee approved the plan early in 1947. It was agreed that the full cost of the medical plan be borne for the first six years on C D and W vote and that thereafter the vote should carry a proportion of the expenditure, decreasing progressively by one-fifth in each of the succeeding four years. [62]

The Gold Coast government on the other hand did not wait until the end of the war to initiate their schemes of development. With this aim in view, Sir Alan Burns introduced an income tax as a means of raising revenue. But the finances for the Gold Coast development schemes were to come, not only from the new income tax and from British grants, but also from the general revenue of the territory. The finances of the Gold Coast government had greatly improved during the war as a result of increased exports and the setting up of petty industries, made possible by the policy of self-reliance promoted during the war.[63] The first Gold Coast Plan drawn up in 1944 asked for limited aid

from the British Treasury. It envisaged a total expenditure of about £5m to be paid for, except for the Imperial grant of £1m, from the Territory's surplus funds. This scheme was concerned with the most immediate needs in the sphere of education and health.[64] In the area of health the scheme involved mainly rehousing in Accra, especially after the earthquake of 1939. It also made proposals for town-planning for the major towns such as Accra, Kumasi and Sekondi.

In 1946, improved financial conditions permitted a more ambitious plan, this time on a ten-year basis, involving the expenditure of £10m. The 1945-46 financial year yielded nearly £500,000 more in direct taxation than the estimate; total revenue amounted to £6,367,820 against the estimates of £4,975,700.[65] The foregoing shows that the finances of the Gold Coast were quite healthy. In the revised Colonial Development and Welfare Act of 1945, the Gold Coast received a grant of £3 1/2m making it even easier for the Government to implement its development plan.

The Gold Coast medical development plan included facilities for both curative and preventive medicine. On the curative side, there was a large increase in hospital construction. Provision was made for a central hospital of 500 beds at Kumasi and fourteen district hospitals, each of forty to ninety beds.[66] As a corollary to the extension of medical institutions new posts were created which included an eye specialist, a venereologist, and assistant director to take charge of medical and health services in the

Northern Territories and six radiographers to operate the X-ray units ordered for an investigation into the incidence of tuberculosis and silicosis in the mining areas and forty-three field assistants for anti-trypanosomiasis work.[67]

The preventive services provided by the Gold Coast Government involved the organization of mass compaigns against yaws, trypanosomiasis and tuberculosis. These mass treatment teams operated mainly in the Northern Territories and in northern Ashanti. In 1951, the trypanosomiasis campaign in the Gold Coast was reorganized and became the Medical Field Unit, similar to the type organized in Nigeria. The Medical Field Unit extended its activities to all rural areas and its scope was widened to include as many endemic diseases as possible. There were altogether four Medical Field Units, organized into arbitrary territorial regions, two (East and West) in the Northern Territories, one for Ashanti and one for Southern Togoland.[68] The concentration of the units in these regions was intended to alleviate the disparity in the provision of health services that hitherto had existed between them and the Coastal areas.

Whereas Nigeria had included provisions for health centres in its development plan, it was not until 1952, when the Gold Coast Government commissioned an enquiry into the health needs of the Territory that recommendations were made for the establishment of health centres in the rural areas, In the Gold Coast, the health centre was conceived as

> a building or group of buildings suitably staffed and equipped to treat minor illness, to offer a limited maternity and child welfare service and to instruct the local community in matters of health and hygiene".[69]

The idea of a health centre meant much more in the Nigerian context - it was an embodiment of all rural medical and health activities. These included not only the field units, the sleeping sickness and leprosy services but also the rural dispensaries and maternity homes. The policy of rural health service in Nigeria was thus centred on a network of health centres.[70]

Unlike the Gold Coast, Sierra Leone had no funds of its own for development and had to rely a great deal on assistance from the C D and W vote. In Sierra Leone a tentative plan for the social and economic development of the Territory was drawn up in 1945. Because of the economic situation of the Territory, the Development Council emphasised that if social services were to be expanded, their expansion must be followed by measures of economic development without which the territory would not be able to maintain them from its own revenue. For the Development Council, therefore, the planning of the railway and road transport services and the construction of port facilities were to be given priority.[71]

However, the medical development plan focused its attention on the Protectorate in order to bridge the gap that had existed between the Protectorate and the Colony. Provisions were made for both curative and preventive

facilities. Health centres and dispensaries were to be increased to a total of two hundred and six. The basis for calculation was one dispensary per chiefdom but the actual citing depended up on a variety of factors - the incidence of disease, communication and population.

On the medical side, a new hospital was constructed at Bo. In 1945 the Bo Hospital provided eighty beds and was built of temporary materials. In the development programme the hospital was to be rebuilt in permanent construction to a capacity of 150 beds, of which ten beds would be for maternity cases.[72] The Northern Province hospital was rebuilt and its capacity increased to 150 beds with fifteen beds for maternity cases. Also, the existing hospitals at Kailahum, Port Loko, Moyemba, Kabala, Pejehum and Bonthe were each expanded to a capacity of sixty beds. Two new hospitals were proposed for Kono and Kenema Districts with a capacity of sixty beds. Of the sixty beds in each hospital, ten would be for maternity cases. Thus a total of 670 general and 110 maternity beds would be provided for the protectorate, bringing the total number of beds to about one per 3,000 populations.[73]

For the colony three new maternity centres were proposed - one in each ward of Freetown. The only existing maternity centre was that provided at the Princess Christian Missionary Hospital in Freetown. Two Health Centres, one at York and one at Waterloo, were provided. However, the largest individual item of expenditure was the construction

of a General Hospital to serve Freetown, the colony area and the adjacent areas of the protectorate.[74] There was also provision for organized compaigns, to be financed by C D and W funds, for the treatment and control of specific diseases notably yaws and sleeping sickness.[75]

Like Sierra Leone, the Gambia had no funds for development and had to rely equally on assistance from colonial development funds. This was due to the collapse of the world price of edible oils and fats, the erection by the neighbouring French Territory (Senegal) of tariff barriers, which deprived the Gambia of a lucrative transit trade in Kola nuts, and decreased receipts from import duties on rice.[76]

The medical and health services of the Gambia during the war lagged far behind those of the rest of British West Africa. They consisted of half a dozen European medical officers, assisted by trained local dispensers and orderlies. Apart from the Victoria Hospital in Bathurst, there was a hospital at Georgetown in MacCarthy Island and a small African Hospital at Bwiam on the South Bank. There were also a few small dispensaries run by African dispensers. A more extensive medical and health service was clearly required.

The Gambia, because of its peculiar situation, presented piecemeal schemes rather than whole development plans. The first medical development scheme was made in 1943, for a free grant of £37,186. This was for certain specific

activities of the department, including the training of medical probationers and probationer nurses, a dental scholarship to be held in the U.K., the employment of an additional medical officer and sanitary superintendent and the erection of a health centre at Basse.[77]

However, the announcement of the funds available for the Gambia in the Secretary of State's circular despatch of 12 November, 1945, involved considerable reductions in the programme. It was therefore decided that the grant for general development should be divided between the medical, educational, agricultural and veterinary departments.[78] The departments concerned had to draw up fresh programmes in 1946. The medical scheme was approved in 1947. It included the construction of a new hospital in Bathurst on the site of the Victoria Hospital, the provision of health centres at Bakau and Brikama, seven lock-up dispensaries in the protectorate and the expansion of Bansang Hospital. On the health side, the most important feature of the scheme was the inauguration of a team of touring staff to be known as the Health Propaganda Unit.[79]

A major public health scheme undertaken by the Gambia Government and sponsored with the C D and W funds was the Bathurst-Kombo-St Mary scheme. The main object of the scheme was the drainage and prevention of flooding of Bathurst, thereby reducing mosquito breeding in swamps.[80]

TRAINING OF MEDICAL PERSONNEL

The training of medical personnel and auxiliary staffs represented one of the most important features of the whole medical and health programme in British West Africa. Large numbers of medical personnel and their anxiliaries were required not only to staff existing hospitals but also to implement development plans.

To promote rural health work the Nigerian government trained dispensary attendants, who received a year's instruction at Zaria or Kano in the north or at Makurdi in the south. In the north, a Medical Assistant School was established at Kano to offer a five-year course similar to that offered at Yaba College.[81]

In all the British West African Territories the long-term policy was to develop nursing as a profession for women. This would take place pari passu with the development of female education. Hitherto nurses in British West Africa had been trained by European nursing sisters during a period of apprenticeship in hospitals. Colonial governments in the 1940s came to regard this system as unsatisfactory because it failed to attract good female candidates into the nursing profession. The Gold Coast and Nigeria hoped that the provision of proper hostel accommodation for nurses in training would go a long way to overcome this difficulty. In the Gold Coast provisions were made for a nurses, training school to be attached to the

Korle Bu Hospital in Accra. In the 1946 Ten-Year Development Plan it was estimated that some 350 trained nurses would be turned out during the ten-year period covered by the plan.[82]

The Nurses Training College at Accra began with six students in January, 1945. From the start its aim was to train Gold Coast girls to the same standard as that of the British- trained state registered nurse. This aim was achieved in July, 1948 when four out of the six Gold Coast girls qualified. However, to ensure that the standard of training in the Nurses Training College was equivalent to that which obtained in Britain it was necessary to pass legislation. The Nurses Ordinance was passed in 1946 and came into operation in April, 1947, and the Nurses Board was instituted to administer the ordinance.[83] In May, 1950, the training given at the Nurses College in Accra and the examination conducted by the Nurses Board of the Gold Coast were recognized as satisfying the requirements of the General Nursing Council of England and Wales for full reciprocity. By 1950, the following hospitals were recognized for the training of nurses in the Gold Coast: the Gold Coast Hospital Accra, General Hospital Kumasi, General Hospital Tamale, the Effia Nkwanta Hospital Sekondi and the Cape Coast Hospital.

In Nigeria, nurses' training schools, one each for the three regions of the Territory, were opened. Midwives were trained in six Government midwifery shools. The standard

aimed at was comparable with that required for the Certificate of Midwives Board in the U.K.[84] The improvement of facilities for local training was necessary, not only for the quality of nurses expected to be produced, but also as a long-term policy - as facilities improved, the need to send candidates to the U.K. would also diminish. However, because of the absence of female candidates with the requisite basic education for training as nurses, there were still shortages of candidates. The colonial governments tried to made good this deficiency partly by the recruitment of ex-Army orderlies and partly by dilution of the highly trained nursing staff with personnel who had served an apprenticeship in the hospitals. Thus the apprenticeship system, made up of partially trained nurses, had come to stay.

In the British Colonies the policy was to recruit qualified nurses and midwives from the U.K., but due to the war few were available for overseas service. Although the aim of colonial policy during and after the war was ultimately to staff the colonial services with locally recruited personnel, the increased social services provided for in the Development Plans called for the employment of trained staff in much greater numbers than most colonial governments could possibly supply. Moreover, the adequate training of colonial staff depended on the provision of instruction and supervision for which purposes large numbers of European nursing administrative and teaching staff were required.[85] The new emphasis on preventive and social medicine meant that the nurse, no less than other medical

workers, was to be selected and trained, not only to care for the sick but also to promote health education. The CAMC was of the opinion that however suitable existing methods in the U.K. or the colonies might be for producing hospital nurses, they could not be considered adequate or appropriate for fitting nurses to undertake rural welfare work.[86] It was precisely to improve the situation that in 1943 Oliver Stanley appointed a committee on the Training of Nurses for the colonies under the chairmanship of Lord Rushcliffe.

The Colonial Secretary appointed this committee after considering a recommendation of the CAMC in favour o f a broadening of the basis of the training given to nurses to conform with the conception that the medical services in the colonial territories ought to be developed as a community service.[87] Sub-committee 'A' that looked into question of training of nurses in the U.K. for the colonies recommended that candidates for the colonial nursing service should be registered in the general part of the Register for the General Nursing Council (GNC) for England and Wales; or should be in the Register of a country with which reciprocal registration had been established. The preventive outlook should be stressed in the course of their training; candidates must be State Certified Midwives; and candidates for appointment as Health Visitors, Superintendents of District Nursing or Midwifery, should hold the Health Visitors Certificate. In addition, tutors or midwifery teachers for training schools should hold the senior tutor's certificate or the midwifery teacher's certificate

respectively.[88] The most important aspect of the committee's recommendations was their emphasis on specialisation. These requirements were essential if European nursing staff were to adapt themselves to changing policies in the colonies.

The training of African medical officers on the other hand was linked to general colonial policy on higher education. Until the war, there were three institutions that provided higher education in the British West African Colonies. These were the Fourah Bay College in Sierra Leone, Achimota in the Gold Coast and Yaba College in Nigeria. Of these, only Yaba provided facilities for the training of medical assistants. The Yaba Medical School was opened in 1930 and was maintained by the Nigerian government. Students admitted here worked towards acquiring the Nigerian local medical qualification. The war, however, had grievous effects on the college since its buildings were requisitioned for war purposes in 1939. By the time the school closed in 1948, it had graduated some sixty-two medical assistants, assistant medical officers and Licentiates.[89]

In 1943, Oliver Stanley set up two commissions of enquiry to look into the issue of higher education in the colonial Empire - the Asquith and Elliot Commissions. The Elliot Commission, appointed in June, 1943, was asked to report on the organization and facilities of the existing centres of higher education in British West Africa and to make recommendations regarding the future of university

education in the region. This commission comprised fourteen educators, three of them Africans - Rev. I.O Ransome-Kuti, K. A. Korsu and E. H. Taylor-Cummings - respectively. The other commission, headed by Mr. Justice Cyril Asquith, was set up two months after the Elliot commission. Its task was to examine what principles should govern higher education in the colonies generally and to explore areas of cooperation between universities and other appropriate bodies in Britain and institutions of higher education in the colonies.[90]

The Asquith commission recommended the establishment of residential university colleges in East and West Africa and the Sudan. These colleges which were to be autonomous and independent of the colonial government were to be affiliated to London University and awarded external London degrees for an interim period until they gained sufficient experience for full university status to be granted. The commission also proposed the creation of an Inter-university Council, on which universities in the U.K. and those in the colonies would be represented to provide common services and a continuity of regular advice in the formation of policies for academic development.

The Elliot commission, on the other hand, published a majority and a minority report. The majority report recommended the establishment of university colleges in Nigeria, the Gold Coast and Sierra Leone; whereas the minority report favoured not only university colleges in each territory but also a West African University College.

The majority report was the one adopted by the Colonial Office. In the area of medical education the commission recommended the establishment of one medical school and one school of dentistry to be located at Ibadan to serve the whole of British West Africa.[91] The urgent need for such an institution cannot be over-emphasised, particularly since colonial governments had embarked on massive expansion of their medical services. Because of the war, the colleges were not opened until 1948. Kenneth Mellanby was appointed the first Principal of the University College of Ibadan.

The faculty of medicine in Ibadan was established to work up to London standard but because of deficiencies in staff and accommodation the course was prolonged to eight years compared with five and a half years in the U.K. This had serious implications for the Medical Faculty as any medical student, who could, would prefer to study in the U.K. Although Ibadan was supposed to be a faculty of medicine for all British West African Territories, the prolonged duration of the course meant that students from the Gold Coast or Sierra Leone would be less attracted to Ibadan under these circumstances. Indeed, by 1951, the Gold Coast was making plans to establish its own medical faculty at the University College of the Gold Coast.[92] Plans for the establishment of Medical School in Gold Coast were, however, discarded in 1952, in spite of the fact that £1.2m had been budgeted for the scheme in the Development Plan. In that year, the commission of enquiry into the health needs of the Gold Coast, recommended that it would be more economical to send medical students abroad than to open a

medical school. This was particularly so since the number of prospective students was still very small.[93] The government of the Gold Coast accepted this recommendation and stressed that the needs of the territory for better organized preventive and curative services must have priority over the provision of an expensive medical school.[94]

The acceptance of this recommendation would appear short-sighted. By October, 1949, there were only thirteen African medical officers, one dental surgeon and one dentist in the Gold Coast.[95] As late as 1952, there were only 152 medical practioners in the Gold Coast - 89 in government service, 28 in private practice, 23 with the mining companies, 6 with Missionary societies, 3 with timber companies and another 3 in Achimota School and University College. Of those in government service, up to sixteen could be absent at any given time. In the Northern Territories there was one Medical Officer to 120,000 of the population; in Togoland the proportion was one to 96,000; in Ashanti, one to 27,000 and in the colony, one to 21,000.[96]

The Medical Faculty at Ibadan was established in spite of all odds. The estimated annual intake was eighty students. The eight years, course was divided up in the following way: an initial period of one or two years in the Faculty of Science devoted to the study of Physics, Chemistry and Biology, in preparation for the first M. B. examinations. This was followed by two years, study of

anatomy, physiology and pharmacology, leading to the second M. B. examinations, and a final period of four years clinical training during which students would be attached to medical schools in Britain. The young faculty was, however, confronted with two main problems: its affiliation to the University of London and as a corollary, the placement of its clinical students in U.K. universities.

In 1951, the Academic Board of the University College resolved on a full enquiry into the future requirements of its Medical School. The advice of the CAMC was sought on the issues mentioned above.[97] At their meeting of 23 October, 1951, the committee unanimously agreed that the recognition of the local degree by the General Medical Council was the preferable method, despite the fact that the curriculum adopted by Ibadan was aimed at London degrees.[98]

Meanwhile a delegation came to London led by Sir Sydney Phillipson - Chairman of the Provisional Council of the college - and including Sir Kofo Abayomi, a member of the college council, and Dr. K. Mellanby, the Principal, together with three members of the Medical Faculty. Their object was to explain the difficulties with which the medical school was faced, to seek cooperation from the U.K. bodies concerned and to secure advice. The delegation had meetings with London University, the Inter-university Council and the Colonial Office.

At the Colonial Office, the views of the CAMC were

presented to the delegation. It was a matter of extreme importance to the Nigerian public that the medical course in Ibadan should lead to degrees of London University. As one of the delegates pointed out, "any attempt to aim at a qualification other than the London degree would be regarded as a ruse leading to a lowering of standards of training and a return to the standard of the Yaba qualification".[99] This view was also strongly supported by the Principal of the University College, Kenneth Mellanby.[100] Thus the Nigerian delegation, through its past experience, was determined to associate the medical faculty with a University in the U.K.[101] At the time, it was thought this was the only way the college could have credibility.

As regards the issue of placing clinical students in the U.K. universities pending the recognition of the facilities at the college, the Colonial Office representatives made quite clear the difficulties involved. Dr. Pridie (Chief Medical Adviser), pointed out that any places allotted to Ibadan students should not be at the expense of other medical students from the rest of the Colonial Empire.[102] In 1952, there were only 621 medical students from the colonies in the U.K. and the Irish Republic of whom 130 were from Nigeria. The average annual intake of colonial medical students was 90.[103]

Two conclusions were reached regarding the principal problems: the medical course in Ibadan would continue to be conducted under the special relationship scheme with London University and would be directed towards the London M. B. B.

S. qualification; maximum help from London University and from the other U.K. universities would be given in the placing of clinical students. The assurances given were, however, in general terms and it was essential for them to be translated into a detailed arrangement with the U.K. medical schools. It was agreed that the Inter-University Council should approach the U.K. universities and possibly take up the matter with the committee of Vice-Chancellors and Principals, if necessary with the object of concluding negotiations by June, 1952, when the first set of clinical students was due for placement.

Generally speaking, the objectives of the development plans were: the expansion of medical and health care facilities to provide a better coverage of the population by a programme of construction of new establishments and the extension and improvement of existing ones; the provision of qualified staff to service these facilities by good training programmes involving the establishment of educational institutions. The plans also aimed to reduce maternal and child welfare mortality by the strengthening and extension of these services as well as provisions to combat the major communicable diseases. The Development Plans also aimed at coordinating these health activities with the work of the planning organization for social and economic development.

The Colonial Development and Welfare Act of 1940 which made planning for social and economic development in the Colonial Territories possible also provided funds for

research into colonial problems. The organization of medical research in British West Africa is the subject of the chapter that follows.

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Development Scheme; CO87/263/6/33226/8 (1948) Bathurst-Kombo-St. Mary Development Scheme. Reclamation and drainage.

81. Yaba College for Medical Assistants was opened in 1930 and was closed in 1948 with the establishment of the University College, Ibadan. See below

82. CO96/781/31498/2 (1945-46) Nurses Training School and Hostel - Accra.

83. (Rhodes House) 722.12 r.14 (16): Gold Coast Nurses in Training.

84. (Rhodes House) 723. 12.r. 283/1957 (1) Nigeria. The Nurse in Training.

85. On the duties and experiences of Nurses and other Medical Personnel in the Colonies See Pat Holden (Rhodes House) 100. 47 S.18 (19) Doctors and other Medical Personnel; Idem (Rhodes House) 100 47 S. 18(18) Nursing sisters in Nigeria Uganda, Tanganyika 1929-1978 (1984).

86. CO859/60/15/12403/12 (1942) CAMC: 416 meeting, 3/2/42.

87. CO9981/1 (1943-45) Committee on The Training of Nurses in The Colonies-Minutes and Papers.

88. CO998/2 (1944) Committee on the Training of Nurses for the Colonies: Sub-Committee 'A' on the training of nurses in the U.K. and the Dominions.

89. N.F.E. Fendell "A History of the Yaba School of Medicine, Nigeria" West African Medical Journal 16, (1967), p. 18.

90. Both Reports were published as white papers in 1945. See Report of the Commission in Higher Education in West Africa (June, 1945), Cmd 6655; Report of the Commission on Higher Education in the Colonies (June, 1945), Cmd. 6647. See also Erik Ashby, Universities: British, Indian, African: A study in the ecology of higher education (London, 1966), pp.211-223.

91. The Elliot Report, op. cit. p. 57.

92. See University of London Medical Delegation, Report: Proposed Medical School of The Gold Coast (1951) in CO859/215/6/12480/22 (1950-51) Medical Schools in British West Africa.

93. Report of the Enquiry into the Health needs of the Gold Coast, op. cit. p. 32.

94. Statement by the Gold Coast Government on the Report of the Commission of Enquiry into the health needs of the Gold Coast (Accra, 1952), para. 29.

95. Appendix D, Report of the Select Committee of the Legislative Council on the Africanization of the Public Service (Accra, 1950).

96. Data compiled from "Report on the Health needs of the Gold Coast", op. cit. pp. 30-32.

97. Kenneth Mellanby to CAMC dated 10/5/51 in CO859/215/6/12480/22.

98. CAMC: Minutes of the 458th meeting, 23/10/51-Medical

Education in the Colonial Territories in Ibid.

99. Sir Kofo Abayomi, visit of Delegation from University College, Ibadan, Nigeria to discuss the formulation of policy for the Medical School at Ibadan", meeting held, 25/2/52 in Ibid.

100. See eg. Kenneth Mellanby The Birth of Nigeria's University (London, 1958), pp. 162-163.

101. Before the war, Fourah Bay College was affiliated to Durham University, while Achimota was affiliated to London University. Both Institutions awarded external degrees of Durham and London Universities respectively.

102. Meeting of a Delegation from the University College, Ibadan 25/2/52.

103. Data provided by J. L. Keith (Director of Colonial Scholars, C.O.), in Ibid.

CHAPTER SIX

POST-WAR PLANNING AND THE ORGANIZATION OF MEDICAL RESEARCH IN BRITISH WEST AFRICA

Before the second world war research in the four British West African Territories and indeed in the whole of the Colonial Empire was carried out as part of regular departmental duties. Research work of this kind was frequently undertaken in response to unrelated series of demands rather than as the outcome of comprehensive planning[1]. This had serious disadvantages, the most important of which was that the system made for duplication and the uneconomic use of funds and scientific manpower. In 1938, Lord Hailey, in his African Survey, recommended not only the setting up of a colonial research fund but also that colonial research should be centrally directed, thus providing for greater coordination. This chapter will consider the general organization of research, particularly as it affected medical research, including the disbursement of funds made available for research and the origins of research initiatives.

THE INITIATION OF A RESEARCH POLICY FOR THE COLONIAL EMPIRE

The need to provide for a comprehensive system of research into the problems involved in the administration of the African territories was realised only during WWII. This

new outlook was a corollary of the changing conception of the obligations of colonial rule which culminated in the passing of the Colonial Development and Welfare Act of 1940.

In a discussion at the Colonial Office with Frank Stockdale[2] in August, 1938, shortly before the publication of his African Survey, Lord Hailey observed (a) that too little research work had been undertaken in the tropical African territories; (b) that the funds for research work in the colonies were not sufficient; and (c) that as the situation then stood, there was no career for a research worker in the African Services[3]. From this analysis Lord Hailey drew the conclusion that the British Government should provide funds for research into African problems and that the funds should be administered by a central managing body. He suggested that a special committee be set up, either under the Privy Council, as was the case with the Committee for Scientific and Industrial Research and the Committees for Medical and Agricultural Research, or under the Cabinet as was the case with the Economic Advisory Council[4].

While the first Colonial Development and Welfare Bill was in preliminary draft form, Lord Hailey's suggestions were incorporated into a Colonial Office discussion held on February 1, 1940, to determine the amount of money to be voted for research[5]. For several reasons the department was in favour of giving assistance for research from U.K. funds. First, grants approved on the recommendations of the

Colonial Development Advisory Committee established precedents for assisting both research and development work which the colonies would otherwise have been unable to undertake.[6] Secondly, some territories were so far from being able to finance research that they could make little progress with the organization of their essential services. Thirdly, many of the problems which needed investigation were not confined to one territory or even groups of territories. Thus without outside help there were bound to be difficulties in administering joint schemes. Fourthly and most importantly, unless funds outside local sources were available, it would be difficult if not impossible for the Colonial Office to influence the coordination of research and encourage schemes as well as obtain the cooperation of non-official bodies. This was fully recognised by Colonial Office officials. In a Colonial Office memorandum it was specifically stressed that the creation of a special fund for research would strengthen the hand of the Secretary of State for the Colonies and his advisers in encouraging the adoption of research schemes by colonial governments. Furthermore, it was pointed out that the creation of such a fund would enhance the value of the advice given by the Colonial Office Advisory Committees. [7]

For these reasons the Colonial Office recommended the establishment of a Colonial Research Fund, to consist of half a million pounds available for expenditure in any one year.[8] It was further recommended that a Colonial Research Advisory Committee be formed to advise the Secretary of State regarding applications for assistance from the

proposed research fund. The functions of the Colonial Research Committee would be - as already stated - to advise the Colonial Secretary regarding applications put forward by colonial governments or the Colonial Office for assistance from the research fund. The committee was also to advise regarding priorities and to suggest schemes for research particularly those in which cooperation by U.K. Institutions was indicated.[9]

Two methods of forming the fund were suggested in the Colonial Office: (a) by the inclusion of a sum in the Colonial Services vote (as had been the case of the funds at the disposal of the Empire Marketing Board) or (b) by Act of Parliament; it was finally established under the Colonial Development and Welfare Act of 1940. [10]

THE COLONIAL OFFICE MACHINERY FOR ORGANISING RESEARCH IN THE COLONIAL EMPIRE

From the time the 1940 Act was passed, the C.O. endeavoured to build up a proper organization for dealing with colonial research matters. Under the Act the Colonial Secretary was responsible to Parliament for the U.K. monies provided for research. Schemes had to be presented by him with the concurrence of the Treasury. Thus it was not practicable to set up an organization responsible to the Privy Council as was suggested by Lord Hailey. Owing to war conditions it was not found possible to appoint the proposed committee at once. The Colonial Research Committee was

however, appointed in June, 1942, under the chairmanship of Lord Hailey.[11] Other members of the committee included Edward Appleton (Secretary of the Department of Scientific and Industrial Research); A.M. Carr-Saunders (Director, London School of Economics); A.V. Hill (Secretary of the Royal Society) and Audrey Richards (a social anthropologist, then working as a (temporary) principal in the Colonial Office. According to Lee and Petter, the Committee "consisted of the scientific Advisory Committee of the Cabinet meeting under another hat, with the addition of representatives from the social sciences."[12]

The Committee did very good work in surveying the whole field of research and defining policy. They published a White paper in November 1943, on its first year of research work. [13] Largely on its recommendation, a series of specialist bodies in the appropriate fields were set up between November, 1943, and February, 1945. These were presided over by eminent scientists: Sir John Fryer - Agriculture; Sir Edward Mellanby - Medical; Alexander Carr-Saunders-Social Sciences; and Arnold Plant for Economic Research. There were also separate bodies on Fisheries, Locust, Tse-tse fly and Insecticides; while the Colonial Products Research Council existed to find new needs for colonial products. [14] Most of the Advisory Committees had specialist sub-committees. For example, the Colonial Medical Research Committee had a Malaria sub-committee and an Helminthiasis sub-committee. In effect the Colonial

Research Committee was delegating to specialist bodies the authority to disburse Colonial Development and Welfare research funds.

Inside the Colonial Office, research questions were dealt with by a separate Research Department under the supervision of an Assistant Under-Secretary. It was staffed by an Assistant Secretary, four Principals and junior staff. Consideration was given to recruiting officers with special scientific experience but scientists with administrative skills were not easy to find.[15] The object was to make the Research Department a Self-contained body in all aspects of research matters - in other words, a kind of "Department for Scientific and Industrial Research" in the Colonial Office.

The Secretary of State also had full-time assistance on various aspects of research by specific officers such as the Director of the Colonial Medical Research Committee. [16] It was one of the principal duties of these officers to pay frequent visits to the colonies to gain first-hand information of the progress made in schemes sponsored by their respective committees. They were also empowered by their Committees to recommend the making of small schemes.

The principal duty of the Research Department was to prepare, and secure Treasury agreement for schemes which were suggested by colonial governments or by scientists in the U.K. Before any scheme suggested by a colonial

government was presented to the Treasury for concurrence, it was first laid before the appropriate committee. Conversely, when any scheme for research in a particular part of the Colonial Empire was suggested by any of the specialist committees, it was first referred to the government of the colony concerned to make certain that they favoured the scheme and therefore would cooperate in its execution. [17] This was an essential consideration, because, clearly, no scheme of research in a Colony would be wholly successful unless the good will and cooperation of the colonial administration was secured.

A further step was taken to stimulate an active interest in the schemes on the part of colonial governments. It became the policy of the Colonial Office to encourage the provision by colonial governments of financial assistance from their own resources and also from Industry. Indeed by 1950, contributions totalling £1 $3/_4$millions had been provided from these sources in the whole of the Colonial Empire. [18] However, such an elaborate organization would be useless without research workers.

THE COLONIAL RESEARCH SERVICE

One of the major factors which had held up research in the Colonies was the lack of skilled workers in practically all fields. Both the Colonial Office and the Colonial Research Committee (CRC) recognised this problem and sought to address it in two different ways: by the creation of

Colonial Research Fellowships and by the creation of the Colonial Research Service.

The need to encourage qualified scientists to give special attention to colonial problems was raised at the 16th meeting of the CRC held on 26 July, 1943. Thus in their first annual report the committee recommended that Colonial Research Fellowships be established for the study of problems in the natural or social sciences which could be more satisfactorily investigated in a colonial territory. The Committee looked to the scheme not only to "secure the answers to important questions bearing on colonial development, but also to familiarise the scientific world at large with colonial problems and so to widen the field from which the colonies and research services can draw the specialist workers whom they will in future require".[20]

A scheme was therefore proposed and submitted to the Treasury in 1944, providing for a free grant of £35,000 from the colonial research allocation, to cover the cost of the award of twenty-five fellowships during a period of five years.[21] The fellowships were normally awarded for two years by the Colonial Secretary on the recommendation of the CRC. They were reserved for university graduates under thirty-five years of age. Although the fellowships were open to candidates from any part of the British Commonwealth and Empire, the idea of awarding them to serving officers in the colonies was ruled out from the beginning.[22] Thus Grossmith minuted, "it is not expected that serving officers will be qualified applicants. I think therefore that it is

hardly worthwhile asking Colonial Governments whether they agree to any particular arrangement".[23] This view was supported by Sydney Caine, who ruled that no communication should be made with colonial governments on the matter. [24] However, the Colonial Office communicated with British institutions informing them of the existence of such fellowships. [25]

The value of the fellowships was £600 per annum (£750 for married fellows). During the first five years of the scheme, only nine fellowships were awarded. [26] At the expiration of this period the Secretary of State decided to extend the scheme for a further five-year period (1949-53).[27]

From its inception the CRC had emphasised the need to attract and retain suitable research workers for the colonies . In their progress report, one of the problems of colonial research which they identified was the shortage of technical staff. They suggested two possible remedies: attention should be given to the conditions of service, while there should be an elastic arrangement to facilitate the exchange of workers between the U.K. and the colonies.[28] From this analysis the committee suggested the establishment of a research service under some central organization in the U.K. (possibly under the Colonial Office which would provide a pool of scientists on which colonies would draw.

The initial plan was the establishment of separate Research Services. Thus in 1943 the Colonial Advisory Medical Committee drew up proposals for the establishment of a Colonial Medical Research and Laboratory Service (CMRLS).[29] Although the proposals were accepted by both the Secretary of State and the CRC, the idea of separate services was abandoned and what eventually emerged was a single unified Research Service. The Creation of a Research Service was seen as a logical corollary to the creation of a central advisory body. The essential point, as emphasised by the Colonial Secretary Oliver Stanley, in communicating the proposal to colonial governments was that "the authority responsible for the planning and coordination of research work must be in a position to command the services of a team of qualified research workers". [30]

The basic intention was to have a Research Service whose members would be able to devote themselves to research. Although the proposal for a Research Service was put to colonial governments in 1945, it was not until 1948 that a final version of the scheme was put to them. This involved arrangements regarding salaries and conditions of service of scientists employed by the Secretary of State and also the method of absorbing serving officers into the Research Service.

The preliminary object of the scheme was to facilitate the flow of research workers from the U.K. to the colonies. For this reason the Colonial Research Service terms of employment and conditions of service provided that new

entrants would receive basic salaries equivalent to those payable to workers of similar qualifications under the Medical Research Council and the Agricultural Research Council. For scientists engaged in research other than medical and agricultural, their salaries were equivalent to those laid down for research workers in the U.K. Scientific Civil Service. [31] This provision enabled the research worker to earn a continuous pension whether or not he spent all his career in the U.K. Indeed, this was the sheet-anchor which held the whole scheme together.

In addition to the basic salary scales, an overseas research allowance was accorded to officers in the Colonial Research Service (CRS). This was an allowance to compensate for service abroad and varied from region to region. In the African territories the allowance was calculated so as to bring the net emoluments of the colonial research worker into line with those of comparable technical officers in the Colonial Service. The rates laid down in West Africa for officers on a basic salary of £1,320 and above was £230 per annum, and on salaries of £1,600 and above £180 per annum.[32]

However, these arrangements were based on the understanding that the service would consist initially of officers directly appointed by the Secretary of State. Its extension to cover serving officers depended on the willingness of colonial governments to allow serving

officers to transfer to the new service and the response of serving officers to a transfer option. [33] As far as the position of serving officers was concerned, it could be argued that this arrangement created a sense of alienation and tended to start the service off badly since the initial members were all 'outsiders'. Indeed, a large and fruitful field of recruitment would have been precisely those already in colonial-government service.

While colonial governments were in general agreement on the creation of a research service as such, they were naturally anxious as to the position of men in the medical and agricultural services, for example, who did a substantial amount of voluntary research along with their ordinary duties. The general feeling was that the research service should not restrict the work done by these officers. The major issue for some colonial governments was the impact of a Research Service on applied research. As early as October, 1945, with regard to medical research, the Nigerian Government expressed the hope that,

> the establishment of particular Colonial Research and Laboratory service [should] in no way imply the discontinuance of applied research by permanent research officers on the Territory's establishment but working under local direction as at present. [34]

A similar view was expressed by the Gold Coast Government.[35]

It was quite obvious that even as proposals on the organization of a Research Service were still under way,

colonial governments in British West Africa recognized that there were major differences of interest between them and scientists in Britain: the latter were concerned with fundamental research whereas colonial governments were concerned with applied research. This was to be expected since colonial officers were more in contact with the local population and were naturally more aware of their immediate needs as far as research was concerned. This had serious long term implications as we shall see later in the chapter.[36]

Meanwhile, the Colonial Research Service came into operation in January, 1949. This service differed from the other branches of the unified services in the important respect that its basic salary scales were tied up with those of the U.K. Scientific Civil Service. There was much delay, however, in implementing the salary scales. First, salaries and conditions of service in the U.K. as well as in the colonial territories were constantly revised during the 1940s and 1950s. In 1950 for example, the Chorley Committee in Britain recommended increased pay for the higher Civil Service. [37] This meant that the terms had to be revised from time to time to conform to such changes.

Secondly, as the Secretary of State's controlling position was progressively weakened by constitutional changes in the colonial territories, colonial governments quite naturally claimed the right to fix their own conditions of employment or delay the implementation of revised salary scales. In 1951, the Nigerian Government, in

reply to a circular from the Colonial Office regarding the revisions made by the Chorley Committee, said, "It is regretted that it is not possible to obtain approval for the new salary proposals in advance of the meeting of the new legislature".[39]

Replies of this nature became frequent in the 1950s. It was primarily in order to avoid deadlock that the Colonial Office in 1955, was forced to adopt a new policy in fixing salary scales for the Research Service. This time, they were calculated territorially in relation to the salary scales of colonial governments and were no longer affected by the salary scales of the U.K. Scientific Civil Service.[40] Thus the terms and conditions of service of the Research Service were brought into line with those of the other unified services or what was known, by 1954, as HM Overseas Civil Service.

It was not only in this respect that the Research Service was brought into line with the other services. In May, 1952, some internal reorganization became necessary in the Colonial Office. One of the major differences between the Research Service and the other unified services was that research workers were centrally controlled by the Research Department while the others were controlled by the Colonial Service Division of the Colonial Office. This meant that the Research Department was in charge of the recruitment, promotions and training of research workers as well as the administration of studentship and fellowship schemes. This

was the arrangement when the terms of the Research Service were still under consideration. By 1952, however, a majority of colonial governments had given their approval to the scheme. It was after this that the C.O decided that the responsibility for filling colonial research vacancies and for new research appointments should be transferred from the Research Department to the Colonial Services Division which handled other colonial service appointments. The Colonial Services Division also took over the administration of the various colonial Research studentships and fellowships. [41]

This reorganisation was necessary because in most cases the type of officer required for the research service was similar to that required for some of the unified services: thus there was bound to be some overlap in the recruitment of persons with scientific qualifications. By this time there were about a hundred officers in the colonial Research Service.[42] In carrying out their duties they were paid from Colonial Development and Welfare research funds when engaged on a central scheme, and if seconded for service with a colonial government, they were paid by that government. This elaborate organization met with considerable opposition from the Colonial Medical Research Committee.

THE COLONIAL MEDICAL RESEARCH COMMITTEE AND THE ORGANIZATION OF RESEARCH FOR THE COLONIES

Following the preliminary discussions between the Colonial Office and the Medical Research Council (MRC), a

meeting was held in the C.O in January, 1945 to set in motion proposals for the creation of a Colonial Medical Research Committee (CMRC). It was agreed that the committee should consist of ten members, exclusive of the Chairman and the Secretariat. The Committee was appointed jointly by the C.O and the MRC in February, 1945. It had as its terms of reference, "to advise the Secretary of State for the Colonies and the MRC on all matters of medical research in and for the benefit of the Colonies". [43]

From its inception the committee had the Secretary of the MRC (first Sir Edward Mellanby and from October, 1949, Sir Harold P. Himsworth) as its Chairman. Following agreement between Sir Edward Mellanby and Sir George Gater, at that time Permanent Under-Secretary of State, there was to be an equal number of nominees by the MRC and C.O. [44] As it turned out, however, all the members of the committee, whether actually appointed by the MRC or not, were closely associated with it. The committee had a joint secretariat composed of an officer nominated by the MRC (Sir John Taylor) and an officer nominated by the Colonial Office. The Colonial Office nominee (first, Dr. Mahaffy and from March, 1949, Dr. R. Lewthwaite) also held the post of Director of Colonial Medical Research.

During the first four years of the committee's existence, colonial medical research rather lagged behind other fields of research. Between 1940, when the first Colonial Development and Welfare Act was passed and March, 1949, only ten per cent of all research grants made were

medical as opposed to 40.5 per cent for agriculture and animal health.[45] Similarly, by 1951 although about one hundred research officers had been appointed for the CRS, only fifteen were medical research officers. Of this number, eleven were appointed to the East African territories and only four for the West African territories.[46]

This backwardness could be attributed to the fact that the committee, unlike all other research committees, was preoccupied with questions regarding its status and the administration of medical research in the colonies. The committee was purely an advisory body, but with the precedent before them of the independence of the MRC from the ordinary administrative machine in Whitehall, they took the view that medical research policy must be controlled and administered solely by medical men. However, whatever might have been practicable in regard to medical research in and for the U.K., the circumstances in relation to the Colonial Empire were quite different.

It was as a concession to the traditional MRC view that Sir G. Gater originally agreed to the committee being jointly appointed by the Colonial Secretary and the MRC. But by the middle of 1947, the committee began to show signs of restlessness and put forward a proposition that the Colonial Office should hand over the administration of medical research in the colonies to the MRC.[49] Sir Thomas Lloyd (then Parliamentary Under-Secretary) saw Sir Edward

Mellanby about this and explained to him that the Secretary of State alone was responsible to Parliament for all activities carried out in the colonies and could not therefore, delegate this responsibility to an outside body.[48] The CMRC accepted this explanation with regret at their meeting of 26 June, 1949.

Another matter on which the committee subsequently showed signs of dissatisfaction was over the institution of the CRS. At their meeting in November, 1949, the committee recorded their disapproval of the idea of medical research workers being lumped in with other research workers in an omnibus research service. Their argument was that the Colonial Office would not succeed in getting the right type of medical research workers by the institution of a special research service and that colonial needs could only be met by the secondment of teams of workers or of individual workers from the U.K. The C.O found itself in a most delicate position because while it desired the cooperation of the CMRC in the recruitment of medical research workers, it wanted by all means to avoid a situation where an enhanced value would be placed on medical research workers.

Things finally came to a head early in 1950. In March of that year, Sir Harold Himsworth, who had succeeded Sir Edward Mellanby as chairman of the CMRC forwarded to the Colonial Secretary - James Griffith - a memorandum in which members of the committee made far-reaching recommendations regarding the organisation of medical research for the colonies. In this document they expressed the need for an

organization for medical research, centrally administered and financed, of general as distinct from local application. This organization was to be separate from the CRS and run by the MRC on behalf of the Secretary of State. Alternatively, some organization external to the Colonial Office should be created under purely scientific direction for handling colonial medical research; such an organization would be directly responsible to the Secretary of State rather than through the Colonial Office. [49] Two major policy issues were raised in this document: responsibility for fundamental or general research; and the delegation of power to an extraneous body.

On the first point, the important question was: should fundamental research be in any way the responsibility of the Colonial Office and the colonial territories and should, therefore, the Colonial Office spend C D &W money on it as opposed to applied research? Much valuable research work had been initiated by colonial governments in the past. Such work was undertaken by individuals with a flair for research work.[50] Hitherto the view had prevailed in Britain that applied research was the responsibility of colonial governments and that fundamental research was really the responsibility of big units such as the U.K, the U.S.A and the United Nations. The question was: how far did this view hold good for the C.O? Surely the C D and W funds were for the benefit of the colonial peoples and only applied research in the colonial territories was likely to benefit them as colonial peoples. Fundamental research could only

benefit them as part of the world population. It was therefore logical that fundamental research should be carried out by the MRC and financed from MRC funds. This of course did not rule out the possibility of the Colonial Office making contributions in recognition of the benefits which would incidentally accrue to the peoples of the Colonial Empire from some of the fundamental research carried out by the MRC. [51]

On the second point, the issue was purely a constitutional one. A distinction had to be made between the delegation of authority and the transfer of authority. It was possible for the Secretary of State to delegate authority but that meant delegation to some person or body that was ultimately subject to his instructions. Thus the Secretary of State could delegate authority to his permanent officials. If, however, there was any question of his entrusting authority to a body which was not under his instruction but on the contrary worked under the authority of a different Minister of the Crown, that was not delegation but transfer of authority. This was what the MRC members of the CMRC had in mind. The Colonial Office could not accept this arrangement as this would have deprived it of control over an important aspect of colonial policy.

The memorandum was exhaustively considered in the Colonial Office after which a rejoinder was prepared.[52] However, James Griffiths, the Secretary of State, decided that before the rejoinder was presented to Himsworth for the consideration of the CMRC, he would first see him. On April

17, 1950, he had an interview with Himsworth; R. Lewthwaite, E. D Pridie and H. Poynton were also present. [53] The main point made by Mr. Griffiths was that for purely constitutional reasons he was unable to delegate responsibility to an outside body on important issues of colonial policy.

This argument disposed of any question of a block grant being made for unspecified purposes to the MRC from C D and W funds. As an alternative, Himsworth asked for a block allocation for colonial medical research, leaving the authority for determining priorities of particular research programmes to the CMRC. The Secretary of State decided to seek the opinion of the Treasury on the issue of a block grant. [54] In reply the Treasury stated quite clearly that "it would not be proper to delegate to the committee [CMRC] the responsibility for the administration and financial control of colonial medical research carried out at the expense of C D and W funds".[55]

Although the rejoinder was sent semi-officially to Sir H. Himsworth it was never transmitted to the CMRC. No conclusive settlement was reached but with the establishment of a separate medical research allocation (£600,000 was made available for medical research up to the end of March, 1956) from the additional C D and W funds provided under the 1950 Act [56] and procedural concessions[57], the CMRC was persuaded to carry on, but their memorandum remained formally on the

table. The issue was revived in 1952, showing that the fire was merely damped down and not extinguished.

This conflict between the Colonial Office and the CMRC had always been quietly played down in the annual reports on colonial research and indeed was hardly ever mentioned. In 1952, Himsworth decided to pose the same issue in a section of the MRC annual report. The draft report was sent to the Colonial Office for comment; it reasserted the value of a single U.K-based organization to cover tropical medical research of general application.[58] Following this, Monson and Lambert of the Research Department went to the MRC on January, 1, 1952, to discuss the memorandum with Himsworth. From their discussion it emerged that the MRC wished to be able themselves to sponsor proposals for colonial medical research.[59] This conflict should never have arisen because as has been shown, within the existing framework, the MRC did in practice have an effective say as regards the way in which C D and W research funds were used. There was also no difficulty in arranging for U.K. - based workers, whether as members of the MRC or as members of Medical Departments of U.K. institutions, to investigate aspects of their work in a colonial territory.[60]

Following his talk with Monson and Lambert, Himsworth abandoned the idea of some kind of unified U.K.-based organization for tropical medical research and apparently withdrew the article on the subject in the MRC annual report for that year. But he sent the Research Department a revised memorandum setting out the aims and needs (as he saw

them) of medical research in the colonies. The broad theme of the memorandum was that the Colonial Office should encourage basic research in tropical medicine in the U.K. and the closer associations of U.K. University departments and MRC units with the work going on in the Colonies. [61] This document was examined in the Research Department and was supported by both the Director of Colonial Medical Research (Dr. R. Lewthwaite) and the Chief Medical Adviser (Sir Eric Pridie). [62] Subsequently, the Colonial Office adopted the policy in principle.

However, while accepting the idea of associating workers and units in Britain with research work in the colonies one or two points had to be taken into consideration. First, as a result of constitutional advancement in most of the colonial territories at this time it was important that such an association should be accepted freely by colonial governments. The need for such mutual agreement was expressed at the third meeting of the West African Council held in November, 1948. At the end of their discussions on the organization of medical research in West Africa, the Secretary of the West African Council (Monson) conveyed the following message to the Research Department:

> as it is the policy of the Secretary of State that colonies should contribute towards the cost of research there should be some liaison, between research organizations and local Governments, which would allow the latter (including if necessary, members of legislative councils) to feel that they are getting value for their money. [63]

This clearly demonstrates that there was bound to be opposition if this arrangement was imposed on colonial governments.

Secondly, the prospect of obtaining contributions from colonial governments for U.K. - based work was very remote, which meant that such an arrangement would rely entirely on C D and W research funds. The question was: what would have to be done if and when such funds were no longer available?

However, by July, 1953, the CMRC, the MRC and the Colonial Office had reached agreement on a statement of policy on the needs of medical research in the colonies. Briefly, this distinguished between two types of research - general or basic research and applied research relating to local problems. The statement further considered the relationship between the two. The point was made that basic work could be carried out either in the U.K or in colonies; while applied research could only be carried out in the colonies. The argument was that owing to the lack of adequate facilities for basic work in the colonies, strong support on the basic side from the U.K was necessary to enable applied work in the colonies to achieve maximum usefulness. [64]

As to the organization of research work based in the U.K, two decisions were made. First, the MRC and medical research departments of universities should associate themselves with research work in the colonies, both by

sending their research workers to the colonies and by attaching other workers to such departments to work in the U.K on special work for the colonies. Second, a number of specialist research workers should be recruited: these would be scientifically responsible to the CMRC and would be available to work either in the U.K or in the Colonies as the need arose. The estimated cost of the programme until 31 March, 1956, was £30,000 and thereafter, £20,000 a year from any future C.D and W funds.[65]

Although this arrangement was hailed in the Colonial Office as a happy outcome to its difficulties with the CMRC (or rather with certain members of it)[66], it marked the triumph of the basic viewpoints of the MRC. These new proposals had several implications. As regards the recruitment and appointment of medical research workers, some members of the CMRC had always maintained that the Colonial Research Service was not attractive to medical research workers. The reason given was that they did not want to accept appointments which might weaken direct or formal connections with the U.K research centres, particularly in view of the uncertain political future of the colonies. This argument did not seem convincing because it was largely in order to meet this difficulty that the Colonial Research Service was invented, but according to Himsworth, this provision did not seem to have allayed the anxiety of prospective recruits. Consequently, in the memorandum referred to above, he suggested that the MRC should, so to speak, under - write appointments by appointing appropriate men to its own staff at the expense

of C.D and W funds. This raises the suspicion that the alleged unattractiveness of the CRS to medical research workers was essentially something fostered by the MRC. Thus by providing this alternative method, the C.O played into the hands of the MRC by giving them effective control through the appointment of staff who would otherwise have been drawn from the service.

A further important issue was the institutionalization of basic research in the U.K by the association of the MRC and medical research departments of U.K universities with medical research work in the colonies. This was effected with regard to the role in medical research of the newly established university colleges. Back in 1945, the Asquith Commission on Higher Education in the Colonies had recommended that as far as possible research organizations should be located near universities. [67] Similarly, the Inter-University Council for Higher Education in the Colonies, recommended in 1949, soon after its establishment that wherever possible research in the field should be linked with centres of higher education. [68]

In 1951, during Himsworth's visit to West Africa, he visited the University College of Ibadan. Kenneth Mellanby, Principal of the College, told him that the medical faculty was anxious to see some research in progress and proposed the setting up of research units there. Without hesitation, Himsworth replied, "while there are excellent facilities for research in Nigeria it would be difficult even in the

absence of financial stringency to justify starting new projects". [69]

This reply was given despite the fact that no medical research programme in British West Africa was associated with any of the university colleges. The importance of such a link could not be easily dismissed. Indeed it would have ensured a continuous relationship between applied and fundamental research and provided a flexible framework within which staff and functions of specialist units could be changed to new tasks as occasion demanded. However, the proposal adopted by the Colonial Office and the CMRC was primarily to satisfy the interests of the MRC.

By implication this meant that medical research schemes could only be initiated from the U.K. Hence colonial governments were more or less barred from determining their own medical research priorities. Little wonder then that some territories initiated and sponsored their own research schemes without recourse to C.D and W research funds. Indeed, medical research programmes in British West Africa were centred on individuals or groups of individuals appointed either by the MRC or by medical departments of British universities. This assessment is clearly illustrated by looking at the major medical research programmes in West Africa.

MEDICAL RESEARCH PROGRAMMES IN BRITISH WEST AFRICA

Largely owing to the impetus given by the C D and W Acts, particularly since 1945, there was a gradual expansion of research activity throughout British territories. The amount allocated to research rose from the £500,000 provided in the 1940 Act to a figure of £13m allocated for the ten-year period ending March, 1956. [70] The later figure was not the total expenditure on colonial research as many of the schemes made under the Acts of 1945 and 1949 were assisted by substantial contributions made by the beneficiary governments. In the area of medical research, the setting up in 1945 of the CMRC meant that the organization of medical and health research became guided by the advice of this committee in London. Under its auspices various individual research projects were carried out. Medical research of this kind was commended as valuable and successful only in the annual reports of the CRC. However, it must be asked whether these projects were relevant to the needs of the people they were intended to benefit or whether they were undertaken just for academic reasons. It must also be asked whether there was any attempt to coordinate research programmes with other development and welfare schemes taking place in the colonies. These questions will be examined in relation to medical research scheme in British West Africa.

Medical research programmes in West Africa were few by comparison with other regions in tropical Africa, particularly East Africa. Expenditure on research in West

Africa was proportionately small in relation to its population. The main projects carried out under the auspices of the CMRC were the Human Nutrition Research Unit at Fajara, Gambia; the Hot Climates Physiology Research Unit, Oshodi, Nigeria and the Loiasis Research Unit at Kumba British Cameroons. There was also the West African Virus Research Institute at Yaba, Lagos. All the projects, except one were based in Nigeria.

The Loiasis Research Unit at Kumba was established in 1949, on the initiative of Professor R. L Gordon, Head of the Department of Entomology and Parasitology in the Liverpool School of Tropical Medicine. The CMRC provided him with a grant of £14,977 for a period of three years. Fifty per cent of the yearly recurrent cost, estimated at £6,500, was met by the Nigerian Government. [71] Loiasis is a filarial disease due to the worm Loa Loa. It is not a killer disease although it causes great discomfort by severe irritation of the skin. The work was undertaken in periodic visits by Gordon and his colleague Kershaw. Although great importance was attached to the discovery of a successful prophylactic, what came out this scheme during the first three years was one publication in an academic journal.[72] By 1952, the unit was threatened with closure because of lack of staff. The unit had been manned by only one permanent member of staff (W. Crewe), who was an entomologist. However, with the establishment in 1952, of the West African Standing Advisory Committee on Medical Research, the management of the scheme was transferred to

the new body and its scope of activities extended to cover the investigation of filariasis in general.[73]

The Hot Climates Physiology Research Unit at Oshodi, Nigeria, also established in 1949, was directed by W.S.S. Ladell of the MRC. The estimated cost of the laboratory up to March, 1952, was £26,000.[74] The unit was closed down in 1956 when its Director was recalled to Britain.

The West African Virus Research Institute at Yaba was originally established in 1943 by the International Health Division of the Rockefeller Foundation and was maintained in cooperation with the four British West African territories. In 1946, the Foundation declared its intention to withdraw from participating in the work of the laboratory by 1948.[75] In 1947, during his visit to West Africa, Professor Maegraith (Dean of the Liverpool School of Tropical Medicine) recommended that on the withdrawal of the foundation the Institute should be taken over by the CMRC and developed as a centre for medical research, principally on virus disease, to serve the needs of the West African territories.[76]

In the same year, A. F. Mahaffy, the newly-appointed Director of Colonial Medical Research, visited Nigeria to discuss with its officials the proposal that the CMRC should assume responsibility for the direction of the Yellow Fever Research Institute at Yaba. It was agreed that the Nigerian Government should place existing buildings including

laboratories, animal houses and staff quarters at the disposal of the committee.[77] In 1949, a C D and W scheme was devised, providing a research grant of £200,000 to cover all the capital cost and 75 per cent of the recurrent expenditure over the five-year period 1950-55; the remaining 25 per cent was met by the four West African governments.[78]

However, as a result of staff shortages, the committee did not assume responsibility until the beginning of 1950. With the withdrawal of the Rockefeller Foundation, the future of the institute looked bleak indeed: during his visit to West Africa, Himsworth acknowledged that "the contribution of the institute to research has been almost negligible".[79]

Indeed, the Institute's activities were confined almost entirely to the production of vaccines. Up to the end of 1947, the vaccines distributed in West Africa were manufactured at the Foundation's Laboratories in New York; but from 1948, the Lagos laboratory began the manufacture of its own vaccine. From January to June, 1949, for example, 38,980 doses of Yellow Fever vaccine were distributed. Of these total 17,560 (45%) were used by the Institute for potency tests. The remaining 21,420 doses were distributed to the British West African territories in the following proportions: Nigeria, 15,820 doses (73.8%); Gold Coast, 2,000 doses (9.3%); Sierra Leone, 3,000 doses (14.0%) and Gambia, 600 doses (2.8%).[80]

Not all research proposals presented to the CMRC were approved. One of these was the proposal for leprosy research present by the Nigerian Government. Leprosy was a serious cause of disability in tropical Africa. It had been shown in 1945 that the incidence of leprosy was highest in the Belgian Congo which had about twenty cases of leprosy per square mile. This was followed by French Equatorial Africa, with sixteen per square miles; Sierra Leone, twelve per square mile and Nigeria, ten per square mile. Indeed, about two-thirds of all lepers in British West Africa were said to be concentrated in Nigeria.[81] It was precisely for this reason that the British Empire Leprosy Relief Association (BELRA) concentrated its biggest effort in Nigeria. Similarly, the Nigerian Government, in their first ten-year Development Plan, embarked on a scheme which would help tackle the problem. This involved the appointment of a Senior Leprosy Control Officer and the expansion of existing institutes in Benin, Warri, Onitsha and Owerri as well as the construction of new settlements.

It was in an attempt to coordinate research work with development schemes that the Nigerian Government, in 1949, submitted proposals for the establishment in Nigeria of a West African Institute for Leprosy Research. It was intended that the scheme would provide facilities for (a) research into epidemiology and chemotherapy of leprosy in West Africa and (b) expert teaching on leprosy of the medical students and post-graduates at the University College, Ibadan. [82] Commenting on the proposal, R.

Lewthwaite, (DCMR), said, "The proposal is to be commended. Its execution will be a notable step forward in the campaign against leprosy in West Africa".[83]

Despite this the Secretary of State, on the advice of the CMRC, rejected the proposal, not only on the grounds that the World Health Organization was developing a leprosy organization but also on grounds of economy in the disbursement of research funds.[84] Ironically, this was the only major research programme proposed by a colonial government in West Africa.

This attitude of the CMRC to a large extent deterred colonial governments from placing before it schemes which they thought were useful for their own development. Instead, individual colonies chose to sponsor their own research schemes. The Nigerian Government for example initiated the Nigeria Malaria Service in 1949 under Bruce-Chwatt without reference to the CMRC. Between 1949 and 1951, a total of £45,500 was spent on the scheme.[85] The scheme involved an experiment on mosquito eradication in Ilaro - Abeokuta Province as well as routine public health work.

In contrast to Nigeria, the CMRC did not sponsor any medical research programmes in Sierra Leone nor in the Gold Coast. Indeed, no medical research activity had taken place in Sierra Leone since the Alfred Jones Research Laboratory, owned by the Liverpool School of Tropical Medicine, was closed down during the war.

In the Gold Coast, the only research activities were those undertaken by the Gold Coast Medical Department, by private agencies and private individuals. The major focus here was on river blindness in the Northern Territories, which had serious effects on the economy of the region. The Gold Coast Medical Department recognized this problem and between 1947 and 1949, appointed M. H. Hughes to investigate the problem of onchocerciasis (a filarial blindness disease carried by the simulium fly found mainly along river banks). He noted that eleven villages along the Sissili Ridge had ceased to exist and more were in the process of dying out.[86] Similarly, in 1950, a team of ophthalmologists sponsored by the British Empire Society for the Blind visited the territory.[87] In the course of their investigations it was estimated that the four British West Africa colonies had a blind population of at least 300,000 (three times the blind population of the U.K).[88]

Research in the Gold Coast also focused on schistosomiasis. Investigations in this field were initiated on the recommendations of F.J. Brady, Medical Director of the Laboratory of Tropical Disease of the United States Public Health Services, during his visit to West Africa under the auspices of the U.S. Economic Cooperation Administration. Brady pointed out that schistosomiasis was widespread in British West Africa but that with the exception of Sierra Leone, the snail hosts of the parasites were unknown. In his view, schistosomiasis was potentially

one of the most serious diseases of West Africa. He therefore recommended that the services of Dr. Elmer G. Berry, Malacologist of the National Institute of Health, Maryland, should be obtained to make a survey of schistosomiasis carrying snails of West Africa. This proposal was warmly welcomed by the four British West African governments and endorsed by the CMRC. A C D and W research scheme was made providing £1,200 to meet the sterling expenditure involved, the remainder being provided by funds from the Economic Cooperation Administration. Berry started his investigations in the Gold Coast early in 1951.[89]

The organization of medical research in the Gambia differed in principle from that in the other British West African colonies in being designed essentially as an overseas station for units based in the U.K. The major research project here was the Human Nutrition Research Unit run by the Medical Research Council as a projection into the tropics of the work of the Human Nutrition Unit at Hampstead under B.S. Platt. Indeed, the development of this project can best be understood in the context of the efforts made to tackle the problem of nutrition in tropical Africa.

NUTRITION RESEARCH

In 1936, the Secretary of State for the Colonies, J. H. Thomas, in a circular despatch to colonial governments drew attention to the work of the Health organization of the League of Nations and to the resolution adopted in the

League's Assembly in September, 1935, urging governments to examine the practical means of securing better nutrition. Mr Thomas requested each colonial government to survey the position in its own territory and to frame a programme for practical measures for the improvement of nutrition.[90] In the light of the replies received from the colonies the committee on nutrition in the Colonial Empire published its first report in July, 1939. This stressed that the main need was for studies of the diet of both rural and urban peoples, including labour employed by mines and plantations. Although published almost on the eve of war, the report concluded with the hope that "the question of nutrition will not be allowed for any reason to fall into the background."[91] The important question then is, what action was taken on the 1939 report?

In order to make provision for field surveys as recommended by the committee on nutrition in the Colonial Empire, the Research Sub-Committee on Nutrition in the Colonial Empire, under the chairmanship of Sir Edward Mellanby, recommended in 1938 that the MRC should appoint a small whole-time staff who would form a scientific nucleus for the purpose of coordinating field surveys. B. S. Platt, who had had experience of nutrition work in China, was appointed the Senior member of the new organization.[92]

A nutrition survey with Platt as Director was carried out in Nyasaland in 1938-40 under the auspices of the Colonial Office the MRC and the International Institute for African Languages and Cultures. Platt was assisted by various

officers including representative of agricultural, veterinary, anthropological, economic, botany, fishery and dietetic interests.[93] This survey was intended to be the first of a coordinated series to be made in different parts of the Colonial Empire under Platt's direction. Wartime calls on staff prevented the fulfilment of this programme as he was recalled to Britain to investigate problems intimately related to the war.[94] Indeed, his report on the Nyasaland survey was never published.

In West Africa, only one or two surveys of limited scope were undertaken. By arrangement with the C. O, F. M. Purcell was appointed by the Gold Coast Government in 1939 to undertake diet and nutrition surveys in the territory. His survey was completed in 1941 but like the Nyasaland survey was never published and no action was taken either by the Colonial Office nor the Gold Coast Government.[95]

Similarly, a nutrition investigation was conducted by G. M. Findlay for the Gambia in 1942. His focus, however, was on the impact of the war on the nutrition of the population. Findlay noted that over a number of years the Gambia had concentrated on the production of a cash crop, groundnut, while foodstuffs, chiefly rice, had had to be imported. During the war, owing to acute shipping shortages, imports, especially of Burma rice, were not only drastically cut down but had also become extremely irregular. This had serious implications for the diet of the population in wartime.[96]

Wartime conditions created a new official attitude towards nutrition. Under the stress of war the emphasis shifted from longer-range work to the daily problems of meeting immediate and essential food needs under drastically altered conditions of supply. This meant an interruption or even cessation of nutritional activities of the type conceived and set in train before the war. At the outbreak of war a review was prepared in the Colonial Office of the position of the colonial territories as regards the production of food for local consumption and the extent of their dependence on imported food supplies. In 1941, Lord Moyne, in a circular to colonial governments, reviewed the general circumstances and emphasised the importance of increasing food production and lessening imports.[97]

The response in the colonies was immediate and practically everywhere considerable efforts were made to stimulate increased food production and reduce dependence on imports. Some indication of the success achieved can be obtained by comparing the values of food imports during the year 1939 and 1940.[98]

Territory	Value of Food Imported		Population	Value of Food imports per head
	1939	1940		£. s.d.
Gambia	17,000	103,000	200,000	7.8
Gold Coast	961,000	747,000	3,787,000	5.1
Nigeria	887,000	696,000	20,589,000	.10
Sierra Leone	157,000	208,000	1,768,000	1.9
Total	2,052,000	1,754,000	26,344,000	

As the table shows, there was an appreciable reduction in the total volume of imported foods principally in the Gold Coast and Nigeria. In the Gambia and Sierra Leone the reduction was less, but this was due to the considerable increase in food requirements compelled by the military situation.[99]

At the same time that efforts were being made to increase local food production, the Colonial Office was also, from 1942, moving towards the development of a scientific food policy for the colonies, in parallel with wartime policy for Britain itself. The main emphasis was on the collection and storing of production data,[100] essential to a planned food economy. To coordinate this information W. M. Clyde was appointed Adviser on food supplies.[101] Unfortunately nothing came of this policy, because most colonies, for lack of the necessary man-power were unable to provide the required data.

In 1941, the Colonial Office arranged with the MRC for Platt to advise on nutritional problems in the colonies. The post of Nutritional Assistant was created early in 1942 and Mrs A. T. Culwick was appointed to it (she had had some nutritional experience in Tanganyika). The idea was to have a working organization in the Colonial Office which would deal with specific questions regarding nutrition.[102] It was also expected that the organization would be part of a wider organization to consider social development and improvement in the colonies as a whole. Thus it became necessary that Platt should undertake further visits to the colonies. However, the greatest hindrance to the arrangement was that Platt was a member of staff of the MRC. When this arrangement was being considered, Sir E. Mellanby pointed out to Dr. Smart that Platt could only be loaned to the C.O on a part-time basis. He further stressed that "the MRC must preserve its identity and that he [Platt] could not be shown as or appear to be part of a government office establishment".[103]

Thus, given Platt's commitment to the MRC and the difficulties the C.O had in getting experienced people to go to the colonies to advise on nutritional problems and make surveys, progress on colonial nutrition came almost to a standstill during the war.

In 1943, Platt expressed his wish to return to the study of colonial nutrition. As a result, in a discussion between

Mellanby and Smart, Sir Edward proposed that a Department of Human Nutrition should be established at the London School of Hygiene and Tropical Medicine with Platt as Director. This proposal was accepted by the Colonial Office and the department was accordingly established in 1943 with temporary accommodation at the National Hospital for Nervous Diseases, Queen Square.[104] Again, as in all other issues of medical research in the colonies, the MRC succeeded in manipulating the Colonial Office thereby dictating not only the pace but also the direction of nutritional research in the colonies. As a result, this was centralised in Britain and controlled by the MRC. The establishment of a Department of Human Nutrition meant that Colonial Nutrition, like Tropical Medicine before it, was institutionalised as a metropolitan discipline.[105] The object of the department was research into human nutrition (both in Britain and in the colonies), the teaching of nutrition as a discipline and the training of nutrition workers.

It was under this set-up that in 1946, a grant of £57,560 was awarded to the MRC to finance for three years a nutritional fieldwork in the Gambia.[106] The purpose of the Field Research Station established at Fajara was to provide facilities for research into problems of human nutrition and food technology. Fieldworking parties were also Stationed at Genieri and Kenaba. The purpose of the Gambia project was to make a survey of food consumption and production, the state of health and nutrition, and the social and economic conditions prevailing in a rural community with a view to the improvement of food supplies. These investigations

were conducted by a medical officer specially trained in nutrition, an economist, a sociologist, an agricultural recorder and a nutritionist.[107]

From 1952 onwards the investigations in the Gambia were expanded to cover other fields of medical research besides those of nutrition.[108] In a letter to Platt on the reorganization of the unit, Himsworth said,

> a total expenditure of some £52,000 p.a of public funds on the Field Research Station and Human Nutrition Research Unit is not justified by the volume of research work at present in progress in the combined establishments.[109]

This was a clear indication that the scheme was a failure and the reasons are not far to seek. If the desire was to plan Field Surveys with the immediate object of improving the dietaries of African peoples in particular areas, there was little need for the very detailed medical examination of large numbers of the inhabitants or for the exact quantitative measurement of the diet eaten such as was done in the Gambia, invaluable though this information might otherwise be. Indeed, the problems involved in changing an inadequate dietary were largely of a sociological, psychological and economic character. The problem of African nutrition had always been treated by European nutritionists based on European experience. On account of the differences in dietary habits and in economic levels, standards which were worked out in Europe and America, especially during the war, were based in large measure on milk, butter and other dairy products, such standards were

not applicable to most African conditions. Any efforts towards the improvement of mass nutrition in Africa could not have met with success unless the following factors were taken into consideration: the low standard of living, local habits in regard to food, the types of food available in different localities and the lack of popular education among Africans. Thus by looking at colonial nutrition primarily as a medical problem nutritional experts failed to address themselves to the root problem.

In West Africa, as has been shown, the problem of nutritional research revolved mainly around B.S. Platt and the MRC. The reorganization of the Gambia Unit in 1952 marked the end of an era in colonial nutrition. Further efforts in this direction came from international organizations such as the Food and Agricultural Organization (FAO) and the WHO. Their role will be discussed in our chapter on international collaboration in medical and health work in Africa.

REGIONAL COORDINATION OF MEDICAL RESEARCH IN WEST AFRICA

The foregoing survey of medical research schemes in West Africa shows that the arrangements for medical research in British West Africa were unsatisfactory; research projects did not reflect the essential needs of the region; and the overall output of research was incommensurate with the expenditure incurred. In Nigeria, for example, by 1951, the yearly recurrent payments from colonial medical research

funds amounted to about £56,350, exclusive of contributions from local governments. The total estimated cost of schemes without allowing for continuation up to 1956, was £360,000. By this date also, the available facilities had been used only by two senior and five junior research workers, together with five workers who visited for limited periods.

This state of affairs could be attributed, at least in part, to the lack of effective central direction in the region. As a result separate research institutes acted without relating to each other and each incurred administrative burdens and heavy overhead expenditure. The lack of central direction also meant that West Africa, unlike East Africa, could not formulate proposals for medical research and present them as a unit. [110] Thus much of the initiative for medical research in West Africa came from outside the region with the result that not much consideration was given to the actual needs of the population concerned.

The situation in West Africa was recognised not only by medical men but also by administrators in these colonies. This group of colonial officials expressed a need for the formation of a central body for medical research in the region. The idea for a central research organization for British East Africa was not new. Moves in this direction were considered premature by the C.O in 1944 when the proposal was first made. At that time, what C.O officials favoured was the coordination of research on a regional basis with regard to the treatment of specific problems

rather than a central organization with executive powers.[111] The issue was further discussed at the third meeting of the West African Council held at Accra in November, 1948, with A. Creech Jones, the Colonial Secretary, in the chair. Here again, there was general agreement that regional research in West Africa should be aimed at specific problems and the Chief Secretary of the Council was given the responsibility of organising research activities on this basis.[112] As a result, by 1949, the following regional research organizations had been set up: the West African Fisheries Research Institute in Sierra Leone; the Virus Research Institute Lagos; and the Tse-Tse and Trypanosomiasis Institute of West Africa based at Vom in Nigeria.[113] As it turned out, this arrangement proved unsatisfactory.

The proposal for the establishment in West Africa of a Central Research Organisation with executive powers was first put forward by the conference of Directors of Medical Services. At a meeting of the Directors held in Accra on 5 June 1950, the Directors,[114] while recognising how essential it was to maintain a link with leaders of medical research in Britain provided by the CMRC, felt that some more direct and local link between the research organizations in West Africa was necessary.[115] Dr. Himsworth, who visited West Africa early in 1951, also put forward similar proposals. He was, however, naturally in favour of the creation of a Central Research Institute which would be controlled by the

CMRC in London. This point was emphasised not only in his memorandum on his visit but also to the CMRC at their meeting of 15 May, 1951.[116]

The outcome of this extensive examination of the problem was the proposal for the establishment of a West African Standing Advisory Committee for Medical Research (WASACMR) put forward in October, 1950, by W. B. L. Monson, the Chief Secretary of the West African Council. This proposal was considered at the Second meeting of the Directors of Medical Services held at Bathurst in May, 1951, and the Committee was constituted later that year. The functions of the committee were: to advise on the order of priority which would be accorded to research problems; to keep under review all research activities; to advise on the means of ensuring that the results of research were applied in practice; to promote the maximum degree of coordination of research work and cooperation between research workers; and to serve as a connecting link between West Africa and other countries.[117] Its first meeting was held in April, 1952.

The Bathurst meeting also recommended that a preliminary survey of medical research with reference to its coordination, direction and encouragement should be made in advance of the first meeting of the Standing Advisory Committee. This recommendation was accepted by the four West African Governments concerned and by the Secretary of State for the Colonies. In December, 1951, a C D and W

research scheme was made to finance the survey.[118] Colonel H. W. Mulligan, the Director of the West African Institute for Trypanosomiasis Research, was appointed to undertake the survey.[119]

Mulligan completed his survey in March, 1952. His report emphasised the need to strengthen the existing organization of medical research in West Africa and made a number of specific proposals designed to bring this about.[120] Mulligan's Report was considered at the first meeting of the Standing Advisory Committee held at Ibadan, in April 1952, and was further discussed at the first meeting of the West African Inter-Territorial Conference held in Accra, in July 1952. Both conferences recommended the approval of the report.

In brief, the proposals embodied in the Report involved the establishment of a statutory body to be known as the West African Council for Medical Research, with general responsibility for the organisation, coordination, and conduct of medical research and for the administration of medical funds placed at its disposal. This council would replace the WASACMR. Furthermore, the existing research units, other than the Leprosy Research Unit, Uzuakoli and the Nutritional Field Working Party in the Gambia, would be placed under the direction of the council. Emphasis was laid on the need for further research, into malaria, tuberculosis (especially in the Gold Coast and Nigeria), yaws, cerebro-spinal meningitis and tropical ulcers.[121] It is interesting to note that right at its inception the

council had identified its medical research priorities. Finally Mulligan was invited to assume the directorship of the new organization. The council was formally established by ordinance in 1954.[122] As a result medical research was decentralised, and local medical authorities were able to have a say in the medical research carried out in their territories. Finally West Africa had its own policy-making body for matters of medical research.

Since the West African Council for Medical Research was established during the last few years of colonial rule in British West Africa, the autonomous role given to the development of medical research in the Region remained largely untested. However, what became increasingly clear was that just as the political ties with Britain were weakening, so were links with the CMRC severed. On the other hand, stronger ties in the area of health and medicine mere being made with International Bodies such as the World Health Organization (WHO) and the United Nations International Children's Emergency Fund (UNICEF), who were showing increasing concern over the health of African peoples. The role of international collaboration in medical and health matters in Africa is the subject of the next chapter.

REFERENCES

1. An example of this kind of research was research into the problems of sleeping sickness in West Africa as shown in my chapter on Medical Research in the Inter-War years.

2. Frank Stockdale was then the Agricultural Adviser to the Colonial Office.

3. CO849/11/1/47002 (1938) Research - Chatham House Scheme.

4. These recommendations were embodied in the African Survey (1938); see p. 1662.

5. "Lord Hailey's African Survey: Proposals for a Colonial Research Fund" Draft memo by Charles Jeffries in C0847/15/9/47097 (1940) Central Direction of Research.

6. The amount approved for research from the Colonial Development fund of 1929 up to the 31st of March, 1938, was £716,235. This included allocations for surveys.

7. Colonial Office memorandum prepared by Charles Jeffries, see not 5 above.

8. At the time of the discussions, Lord Hailey was preparing to go on a tour of Africa. It was decided to announce the setting up of the fund before his arrival in Africa, emphasising the part he played in securing it. It was thought in the C.O. that this would be of value to him in the personal contacts he would be establishing during his tour. See for example, minute by F.J. Pedler, 4/1/40 in Ibid.

9. Colonial Office Memo. see note 5..

10. It may be noted that no time limit was laid down in the Act for the provision made for research, in contrast to the ten-year limit assigned for expenditure on development and welfare projects.

11. The idea was that the committee should have an authoritative chairman who was not himself a distinguished research worker.

12. J.M. Lee and M. Petter, The Colonial Office, War and Development Policy: Organization and the Planning of a Metropolitan Initiative, 1939-45 (London, 1982) p.184.

13. Cmd. 6486 (1943) Progress Report of the Colonial Research Committee.

14. Information gathered from CO 927/14/1/28001 (1947-48) Research Policy - General organization of Colonial Research.

15. See Ibid.

16. The post of Director of Colonial Medical Research was first created in 1947 with the appointment of Dr. Mahaffy, who, until then was Director of the Yellow Fever Research Station at Entebbe, Uganda.

17. CO927/121/4/28001/75 (1950) Research Policy.

18. Ibid.

19. Cmd. 6535 (1943-44) Colonial Research Committee: First Annual Report.

20. Ibid. P.6.

21. CO927/2/12801/1 (1943-44) Colonial Research Fellowships.

22. This was due to the age limit imposed.

23. Minute by Grossmith, 16/10/44 in CO927/2/1/2801/1 (1943-44), op. cit.

24. Minute by S. Caine, 18/10/44 in Ibid.

25. Secretary of State, Oliver Stanley, to British Institutions (oct. 1944), in Ibid.

26. CO927/15/4/28004 (1948) CRC - Papers circulated.

27. CO927/17/2/2801 1 (1947-48) Colonial Research Fellowships.

28. Cmd 6456, op. cit., p.11

29. On these proposals see "Tentative plan for colonial Medical Research and Laboratory Service" in CO859/61/4/12403/18 (1943) CAMC; CO859/110/1/12471/3 (1944) Coordination of Medical Activities in the Colonies: Medical Research Proposed establishment of a CMRLS.

30. Oliver Stanley to Colonial Governments, 15/3/45 in CO927/1/28001/1 (1945) Research General: Research Policy.

31. CO927/131/8/28047 (1950) Colonial Research Service.

32. Ibid.

33. CO927/132/4/28047/14 (1950) Colonial Research Service PT. II: Appointment of Serving Officers.

34. Arthur Richards (Governor, Nigeria) to G. H. Hall (Colonial Secretary), dated 3/10/45 in CO927/1/28001/1 (1945). opp. cit.

35. See Gold Coast No. 216, OAG to O. Stanley, 25/7/45 in Ibid.

36. In the early 1950s, colonial governments in British West Africa called for the setting up of a West Africa Advisory Committee to be controlled by the Government concerned. The idea was that it was only through such organization that the medical research needs of the Region could be more properly addressed.

37. Cmd. 6735 (1950) Recommendations of the Chorley Committee on Remuneration of the Higher Civil Service.

38. CO927/131/8/28149 (1950) CRS - Terms of Service.

39. Nigeria Savingram, 14/11/51 in CO927/131/24047/10 (1951): CRS PT. II -Terms of Service.

40. Sir Charles Jeffries (ed), A Review of Colonial Research 1940-1960 (London, 1964), p. 34.

41. CO927/132/1/28097/9 (1949-52) CRS - Organization.

42. Ibid.

43. C0913/1/ (1945) CMRC - Minutes and Papers.

44. This arrangement was arrived at in a discussion between the two officers on 7/12/43 See "CMRC - Introductory note before the first meeting in Ibid.

45. CO927/14/3/28001/1 (1949) Research Policy - Relation of research to Development plans.

46. C0927/132/6/247/14/62 (1951) CRS - Appointment of Medical Research Workers.

47. C0927/14/1/28001 (1947-48) Research Policy General.

48. Ibid.

49. CMRC: Memo on The Organization of Medical Research for the Colonies: in C0927/175/1/28401 (1950) CMR - General Policy.

50. See for example memorandum by Dr. Hennessey on the scientific papers by members of the Colonial Medical Service 1930-1949 in C0927/88/3/28449 (1948-49).

51. The C.O. had already worked out a scheme for assisting Research Institutions in the U.K. from Colonial Research Funds. See CO927/2/4/28020 (1944-45) Forms of assistance to Research Institutions. The Fajara field Research Station and the Applied Nutrition Unit in the Gambia which were respectively administered by the MRC and the London School of Hygiene with funds provided in part from Colonial Research funds are notable examples.

52. "Organizations of Colonial Medical Research in the Colonies: Note by the Secretary of State for the Colonies" in C0927/175/1/28401 (1950) Colonial Medical Research: General Policy.

53. Minute by Sir Hilton Poynton to Eastwood 18/4/50 in Ibid.

54. The Treasury's view on the matter were sought in a letter by C.G. Eastwood (C.O.) to H. Clough (Treasury) dated 1/6/50 in Ibid.

55. A.H. Clough to C.G. Eastwood, 1/7/50, in Ibid.

56. C0927/238/146/01 (1950-53) Allocation of C D and W Funds for Medical Research.

57. The concession was that the authority for determining priorities of particular research programmes was left to the CMRC and the Director of Colonial Medical Research but of course, with the customary C.O. and Treasury concurrence.

58. Draft Report in C0927/289/81/02 (1952-53) Colonial Medical Research Policy.

59. See minute by Monson, 3/1/52 in Ibid.

60. As we shall see later in the chapter, much of the Medical research work carried out in British West Africa during this period was initiated either by the MRC or by individual Scientists from U.K. Universities.

61. "Medical Research for the Colonies", Memo by Sir H. Himsworth in C0927/289/81/02 opp. cit.

62. See for example minute by Lewthwaite, 6/3/53 and minute by E.D. Pridie, 7/3/53 in Ibid.

63. Encl. 2 WAC: Conference of Directors of Medical Services," organization of Medical Research in West Africa in W.B.L. monson to J.G. Hibbert, (Research Dept. C.O.), 6/6/50 in C0927/176/7/28410/9 (1950) Regional Coordination of Medical Research: West Africa.

64. This statement of policy could be found in C0927/289/81/02 (1952-53), opp. cit.

65. The £30,000 which it was anticipated should be necessary to implement the proposals was taken into account in the reallocation of research funds between the various heads of research expenditure by the Colonial Research Council at their meeting held on 17th July, 1953.

66. See Minute by A.H. Poynton, 4/8/53 in CO927/289/81/02 op. cit.

67. Cmd 6647 (June, 1945) Report of the Commission on Higher Education in the Colonies. P. 29.

68. Walter Adams (Sec. Inter-university Council) to J.G. Hibbert (Sec. CRC) 27/10/49 in CO 927/15/3/28001/75 (1949) Association of research activities in the Colonies with University Institutions.

69. Medical Research in West Africa: Memo based on a visit by Dr. H.P. Himsworth (Chairman, CMRC) to the Gambia, the Gold Coast, Nigeria, the Sudan, Uganda, Tanganyika and Kenya form 28th Dec. 1950 to 12th Feb. 1951 in CO927/175/2/2840 (1951) CMR-General policy.

70. Figures provided in CO927/15/1/28001/7 (1948-49) provision for Research in CD and W Acts.

71. CO927/87/4/28439/9 (1949) Helminthiasis Research - Loiasis, Kumba - West Africa.

72. See W.E. Kershaw "Loiasis Research Kumba" Annals of Tropical Medicine and Parasitology Vol. 45 Nos. 3 and 4 (Dec 1951).

73. C0927/182/5/28439/9 (1952) Helminthiasis Research, West Africa - Loiasis Research Unit - Kumba

74. C0927/175/2/28401 (1951) Colonial Medical Research - General Policy.

75. See "The future of the Rockefeller Foundation Institute in Entebbe, Uganda and Lagos, Nigeria" and CMR (46) 38 in CO/913/1 (1945) CMRC- Minutes and Papers.

76. B.G. Maegraith "Development of Medical Research in West Africa" Report of a visit to Sierra Leone, Gold Coast, and Nigeria, November-December, 1947 in CO927/85/4/28425/13 (1948) Medical Research Institute Alfred Jones Research Laboratory, Sierra Leone.

77. A.F. Mahaffy "Notes on a visit to Lagos" in CO927/86/2/28432/12 (1946-47) Virus Research - Yellow Fever Research Institute, Lagos.

78. CO927/86/4/28432/12 (1949) Virus Research-Lagos, Nigeria.

79. H.P. Himsworth, "Visit to West Africa", opp. cit.

80. Data compiled from CO927/181/28452/12/4 (1949-50): Virus Research: Yellow Fever Research Institute, Technical Papers. p. 3

81. A.D. Power "The Leprosy problem in Africa" African Affairs, Vol, 44 (1945-46), pp. 81-85.

82. CO927/85/5/28426/9 (1949) Leprosy in West Africa

83. Minute by R. Lewthwaite, 9/10/49 in Ibid.

84. A. Creech Jones to the Government of Nigeria, 24/2/50, in Ibid.

85. The Nigeria Malaria Service had its head-quarters at Yaba and was funded from C D and W funds through the territorial allocation for Nigeria. See CO583/307/30572/5 (1951): Planning and Reorganization - Medical Schemes.

86. On Hughes's investigations see his manuscripts deposited with Rhodes House: MSS Afr. S141, ff. 27-41 "Depopulation in sissili Area - Gold Coast (1947-49). On research into the problems of Blindness in the Gold Coast See C0927/183/5/28444 (1952): Research on the causes of blindness in the Colonies.

87. The British Empire Society for the Blind was inaugurated in January, 1950 with John F. Wilson (himself blind) as its Secretary. The Society was under the direction of the Executive Council whose members were appointed jointly by the Secretary of State for the Colonies and the National Institute for the Blind.

88. Report of the Executive Council of the BESB, 1950 in C0927/183/5/28444 (1952), op. cit.; See also J.F.Wilson "Blindness in Colonial Africa" African Affairs Vol. 52 (1953), pp. 141-149.

89. See Report by Chief Secretary, West African Inter-Territorial Conference (A.N.Galsworthy): First Meeting (28/4/52) in C0927/124/5/28021/9 (1952) Regional Coordination of Research - West Africa.

90. J. H. Thomas to Colonial Governments dated 18/4/36 Appx. I Cmd. 6050 (1939) Committee on Nutrition in the Colonial Empire: First Report - Nutrition in the Colonial Empire.

91. Ibid. p. 168, para. 64

92. C0323/1569/3550 (1938) Nutrition

93. C0859/33/4/12603 (1940) Nutrition Research Surveys

94. From 1940 onwards Platt was appointed one of the Secretaries of the Scientific Food Policy Committee, an Advisory Committee of the War Cabinet Committee on Food Policy. In this capacity he was concerned with working out Britain's wartime food policy.

95. See F.M. Purcell "Diet and Ill-health in the Forest Country of the Gold Coast (1941) in C0859/61/1/12605/c/1 (1941-43) Research Survey-Gold Coast.

96. C0859/67/13/12601/9B (1943)m Nutrition in the Gambia: G.M. Findlay "Report on the Nutrition of the Civilian population of the Gambia" (22/12/42).

97. Circular despatch dated 29/9/41, Lord Moyne to Colonial Governments in CO852/468/3/18300/AC (1941) Food Production.

98. Data compiled form CO859/468/3/18300/Ac, opp. cit.

99. With the fall of France in mid-1940 and the entry of Italy into the war, the Mediterranean was closed and shipping which would normally have passed through that sea was diverted round South Africa and assembled at Freetown for convoy. Dakar could no longer be used as a fuelling point and Freetown was subsequently used for that purpose. With the absence of French protection to the north, local defences had to be strengthened. European troops were sent to Sierra Leone, native levies were raised and a large number of labourers were employed in constructing defences, making aerodromes etc.

100. On Scientific food policy for the Colonies See C0859/67/12601/10 91942) Scientific Food Policy; C0852/468/1/18300/A1 (1942) Food Production: Colonial Nutrition Policy in wartime.

101. C0866/39/1562 (1942) Adviser on food supplies.

102. Discussions on the need for the formulation of such an organization can be found in C0859/67/15/12603 (1941) Research Survey.

103. Minute by Smart (Chief Medical Adviser, C.O.) dated 22/12/43 in C0859/68/10/12627 (1943) Nutrition organization.

104. The results of this discussion are recorded on file C0859/68/3/12617 (1943) MRC - formation of Nutrition Department.

105. On the institutionalisation of tropical medicine in Britain see Michael Worboys, "Science and British Imperialism, 1895-1940" (Ph.D. Thesis, Sussex University 1979). Ch. II "Tropical Medicine and Colonial Imperialism, 1895-1914". pp. 83-142.

106. C0859/115/7/12626/8/1 (1946) West Africa - Field working Party - Gambia.

107. The idea of the combined attack was not new. The main difference between this scheme and the Nyasaland one before the war was that the emphasis had shifted from field survey to field experiment.

108. C0927/183/8/28452/10 (1952) Colonial medical research field Research Station, Fajara.

109. H.J.P. Himsworth to B. S. Platt dated, 16/4/52 in Ibid.

110. The regional coordination of medical research and indeed research in general took off much earlier in East Africa than in West Africa. The success of this arrangement could be attributed to the fact that there was already a precedent for cooperation in the region beginning with the closer 'Union Movement' of the 1920s. The movement culminated in the establishment of the East African High Commission in 1948. On the regional coordination of research in East Africa see for example, Ann Beck "The East African Community and Regional Research in Science and Medicine", African Affairs Vol. 72 (1973), pp. 300-308;

Idem, "Medical Administration and Medical Research in developing countries: Remarks on their History in Colonial East Africa" Bulletin of the History of Medicine (1972), pp. 349-358.

111. C0927/3/1/28021/9 (1944) Regional Coordination of Research: West Africa.

112. C0927/21/5/28021/9 (1948) Regional Coordination of Research: West Africa.

113. C0927/14/3/28001/1 (1949) Research Policy.

114. The Directors present at the meeting were : G.B. Walker (DMS, Nigeria); R.L. Cheverton (DMS, Gold Coast); F. Maclagan (DMS, Sierra Leone); and E.J. Bury (DMS, Gambia). Also present were W.B.L. Monson (Secretary, West African Council) and E.D. Pridie (Chief Medical Adviser, C.O.).

115. Encl. WAC - "Conference of Directors of Medical Services in West Africa" dated 5/6/50 in C0927/176/7/28410/9 (1950) Regional Coordination of Medical Research in West Africa.

116. Memorandum on Himsworth's visit to West Africa, opp. cit. p. 10; CMRC - Minutes of 26th Meeting, 15/5/51, in C0927/175/6/28403/1/1 (1950-52), CMRC - Agenda and minutes.

117. See "Note by the Secretary, West African Inter-Territorial Secretariat, 15/2/52 to the Secretary of State" in C0927/27/122/3/28008/A (1952) CRC - Annual Reports.

118. CO927/115/5/28001/7/3 (1951) Allocation for Medical research: debits and credits: Medical Research Survey in West Africa.

119. Mulligan was a member of the Medical Research Department of the Government of India from 1923 to 1946 and directed the Central Research Institute at Kasanli from 1944-46. As a result, he had extensive knowledge and experience of the organization and requirements of medical research.

120. H.W. Mulligan "Report on Medical Research in the British West African Colonies" (March, 1952).

121. CO927/177/1/28410/9 (1952) Regional Coordination of Medical Research, West Africa.

122. Ibid.

123. On the general organization of the Council see CO927/291/81/11/03 (1953-54) West African Council for Medical Research Organization.

CHAPTER SEVEN

INTERNATIONAL COLLABORATION IN HEALTH WORK

HISTORICAL BACKGROUND

The principle of international collaboration in the field of public health is not new.[1] The first definite movements towards international cooperation in public health date from the first half of the 19th century, when a series of epidemics of cholera and plague swept across Europe from the east. Every country dreaded these scourges, and each attempted to protect itself by the methods which its officials judged to be possible and effective. What came out of this was quarantine. The inconveniences caused by such unilateral action to rapidly expanding communications and commerce became so great that several attempts were made to arrange a meeting of representatives from the different interested nations. In 1851, an International Conference was held in Paris to try to reach some mutual understanding on the Sanitary requirements of shipping in the Mediterranean.[2] The immediate results of the conference were negligible but it was followed by a series of similar conventions during the second half of the 19th century. These culminated in 1907, when, under the agreement signed in Rome, the first permanent world-wide body dealing with international health and primarily with quarantine was created. This was the International Office of Public Health in Paris.[3] The Paris Office had the following terms of reference:

> To collect and bring to the knowledge of the participating States the facts and documents of a general character which relate to public health and especially as regards infections diseases notably cholera, plague and yellow fever as well as the measures to combat these diseases.[4]

With the emergence of the League of Nations after World War One, a Health organization was created in 1923 which consisted of a General Advisory Council with the same membership as the committee of the International Office of Public Health.[5] These two organizations were not formally amalgamated but continued to function separately under a specially arranged system of liaison.[6]

In 1926, an International Sanitary Conference was organized by the Paris Office; this resulted in the basic Convention which governed quarantine by sea and land until the outbreak of the second world war. Under the Convention first cases of plague, cholera and yellow fever and epidemics of typhus and smallpox were to be notified to the Paris Office. By 1933, the growing importance of international aviation and the possibility of the introduction of epidemic diseases by air traffic prompted an International Sanitary Convention of Aerial Navigation held at the Hague. This convention was ratified in 1935 by ten signatories.[7]

Hither to African territories were not directly represented in the international conventions although they were obliged to report cases of infectious diseases. This

was effected naturally through the various colonial powers in the region. The 1926 convention, however, prompted the Union of South Africa to approach the League of Nations to convene an African Health Conference: the Union Government was concerned to promote the adoption of uniform regulations for the prevention of the spread of smallpox (particularly from India) and the study of problems arising out of the continued prevalence of plague in certain areas of South Africa.[8] The Conference was held in Cape Town in November 1932 under the auspices of the League of Nations and the Paris Office. Most British territories in Africa, including Angola and Mozambique were represented. The major subjects considered were the transmission of yellow fever by aircraft, plague in Africa and rural hygiene.[9] Furthermore, the conference called on the Paris Office to record from time to time the progress of plague in African territories and make the information available to the health administrations of all countries interested. The Permanent Committee of the Paris Office accordingly considered the means by which the request could most suitably be met. It was decided that the general application of the International Sanitary Convention of 1926 should be extended to cover the African territories.[10] The 1926 convention stipulated that in a country, or a region of a Country, hitherto unaffected, the first appearance of human plague was to be reported by telegram to the Paris Office. This first notification was to be followed by a written communication giving details of importance regarding the locality affected, the type of disease, the origin of the outbreak and so on. The Office would then take the

necessary steps to inform public health administrations generally of all information thus received.

The Cape Town Conference of 1932 was a stepping stone for the African territories. From then on quarantine matters as well as other public health issues in the region were looked upon in a world-wide context. To formalise the arrangement, in 1933, A T Stanton, Chief Medical Adviser at the Colonial Office, was appointed a permanent member of the Paris Office, representing British colonial territories. Similarly, in 1935, African colonies were required to notify the Paris Office of outbreaks of infectious diseases directly rather than through the various health ministries of the colonial powers concerned.[11]

The first Pan-African Conference was held in Johannesburg in November, 1935. Further discussions took place on hygiene and medical services in rural areas, the provision of medical services for the indigenous population, the training of African medical subordinate personnel, protective measures against the introduction of yellow fever and preventive measures against the spread of plaque, typhus and other infectious diseases.[12] A second Pan-African conference was projected for March, 1940, but as a result of the war was cancelled.[13]

Although the initiative taken by the Union Government to internationalise the problem of public health in Africa could be seen as an attempt to project its national image in international politics,[14] the issues discussed at these

conferences were of vital importance to the health policy of British territories in West Africa. Indeed, issues such as the expansion of medical services to the general population and the training of African subordinate staffs, increasingly received the attention of colonial governments in the 1930s.

Generally speaking, the 1930s could be seen as the decade during which there developed a marked international interest on the health problems of the African peoples. This interest was reflected not only in the organization of the Pan-African Conferences but also in a number of International Conferences to which colonial territories in Africa were invited to send their delegates. Notable among these were: the Leprosy International Congress held in Cairo in March, 1937; the International Congress of Tropical Medicine and Malaria held in Amsterdam in September, 1938; and the Maternity and Child Welfare Conference held in London in June, 1937.[15]

During the Second World War, it became clear that the two principal existing International Conventions relating to quarantine (the I.S.C. signed at Paris in 1926 and the I.S.C. for Aerial navigation signed at the Hague in 1933) stood in need of revision: the provisions for existing conventions had been outmoded by scientific medical progress as well as the increasing importance of air transport during the war. As a result, in 1944, the United Nations Relief and Rehabilitation Association (UNRRA) proposed the revision of the International Sanitary Conventions. A new Sanitary

Convention was accordingly drafted in Montreal, Canada, by the European Technical Advisory Committee on Health, a subcommittee of the UNRRA.[16] The draft convention embodied the preliminary discussions between members of the Expert Committee on Quarantine and members of the United States Public Health Service and the Pan-American Sanitary Bureau. Amendments made by the Colonial Office were also incorporated. The Colonial Office amendments were designed to render the convention more readily applicable to colonial conditions and thereby facilitate its acceptance by colonial governments.[17] Also included in this revision was the temporary replacement of the Paris Office by the Health Division of the UNRRA.

In 1948, with the creation of the World Health Organization (WHO), the duties and powers of the Paris Office, the Health organization of the League of Nations and the UNRRA were handed over in principle to the new body. The organization, under article 21 of its convention, was to adopt regulations concerning sanitary and quarantine requirements and other procedures designed to prevent the international spread of diseases.[18] To this end, the organization, appointed in 1948 Expert Committee on International Epidemiology and Quarantine under the chairmanship of Dr M. T. Morgan of Britain. The Committee was entrusted with, inter alia, the task of preparing International Sanitary Regulations to replace and revise the existing Conventions.[19]

By 1949, the Expert Committee had drawn up new International Sanitary Regulations. Their provisions followed the technical principles which governed the application of International Sanitary Conventions between 1903 and 1944. The Regulations incorporated current knowledge in epidemiology and prophylaxis aimed at ensuring maximum security against international transmission of communicable disease without interfering with world traffic. The committee emphasised the need for each country to develop its internal resistance to disease rather than rely on measures taken at the frontiers. Measures such as immunization and destruction of insect-vectors were considered relevant.[20] Thus the importance of preventive measures was recognized. In May, 1950, the Regulations were adopted by the Fourth World Health Assembly and Colonial Governments were accordingly informed.[21]

Generally speaking, the International Office of Public Health in Paris had been concerned mainly to gather information regarding quarantinable diseases and to revise conventions. The office had no powers to do fieldwork; it worked solely by conferences and correspondence. Thus international collaboration in public health before the second world war was restricted to epidemic intelligence, and even this was mainly directed towards stopping the major diseases from spreading to developed countries. The possibility of fighting disease on a broad front everywhere had hardly been considered. After WWII and the creation of the United Nations, all countries of the world formally

undertook to join in a common endeavour, not only to protect themselves from the spread of epidemics but also to attack communicable disease wherever it is found. Thus from dissemination of information on pestilential diseases, the principle of international collaboration on public health progressed to the pooling of knowledge, experience and resources to provide direct assistance to countries in promoting the health of their people.

Meanwhile, while the specialised agencies of the United Nations were still being set up, international collaboration of a technical nature was being promoted in Africa. This was collaboration between the various colonial powers in the region.

INTERCOLONIAL COLLABORATION

At the outbreak of the second world war an effective system of cooperation had developed between Britain, France and Belgium on a wide range of technical matters of common concern to the African territories for which these governments were responsible. Intercolonial cooperation in Africa before WWII was very limited and in certain areas non-existent. At a European level however the principle of international cooperation had long been enshrined in conventions such as those discussed above. The absence of inter-colonial cooperation in Africa in the inter-war years could be explained by the fact that initially what was important to colonial powers was the establishment of control over their respective territories rather than cooperation on matters of common interest. Indeed, the

initial relation between colonial powers in Africa were marked more by hostility than cooperation. This spirit could be traced back to the Berlin conference of 1884-85.

Between the wars, especially in the 1930s, there were, as we have seen, international congresses in which African territories were represented[22] but these were not inter-governmental efforts to deal with technical problems. Most of the congresses held in the area of health and medicine were organized by voluntary agencies and international organizations interested in specific diseases. The general attitude adopted by Colonial powers and Colonial administrations implied that nothing which happened in British territories could ever be of the slightest interest to the neighbouring French, Belgian or Portuguese territories. For West Africa there was a Yellow Fever Conference at Dakar in 1928, attended by medical and health representatives of both British and French territories but nothing came from it.[23] In 1929, W. B. Johnson, the Director of Medical services for Nigeria, undertook a tour of the French, Belgian and Portuguese territories to see how the various administrations tackled the sleeping sickness problem. This was more an individual initiative than an inter-governmental cooperation.[24]

The absence of inter-colonial collaboration between the wars was not peculiar to public health and medicine.[25] It took the impact of war to change the situation. In October, 1939, Malcom MacDonald, the Colonial Secretary, visited

Paris. During his visit early steps at cooperation with the French Government were taken in the area of production and supply, designed as part of the war effort.[26] This cooperation was however interrupted when France was invaded by the Germans in June, 1940. Soon after the end of the war in Europe, Britain took steps to resume and extend Anglo-French collaboration on technical matters. In November, 1945, there were meetings between officials of the two Colonial Offices designed principally to ascertain which particular technical questions could best be made the subject of cooperation between the two nations.[27] Similar talks with the Belgians were held in June 1946 and January 1947, While the French and the Belgians held discussions with one another on similar lines to those which both had previously held with the British.[28] The foundations for closer cooperation with the Portuguese Government and the Portuguese territories in Africa were laid when a party of Portuguese officials visited the Colonial Office in December, 1947.[29]

These various bilateral discussions culminated in tripartite Anglo-French-Belgian discussions held in Paris in May, 1947. The object of the meeting was to ascertain exactly what research was being carried out and what research organizations existed; to establish what gaps needed to be filled and where overlapping could be avoided; to consider whether any joint enterprises should be taken and to establish machinery for the efficient exchange of information and visits.[30] As a result, a three-year programme of technical conferences was agreed upon.

The first Anglo-French technical Conference took place in Dakar in May, 1946; it was a veterinary conference. This paved the way for a medical conference convened at Accra in November, 1946. Although sponsored by the French and British, invitations were sent to Liberia, the Portuguese and the Belgians. The Accra conference was thus an immediate departure from the bilateral framework, hence, regional cooperation in medicine began to spread well beyond the limits of West Africa. In 1948, the Inter-African Conference on Trypanosomiasis saw for the first time, with the full support of the governments and the territories concerned, the gathering of representatives from all territories in Africa south of the Sahara - the British, French, Belgium, Portugal, Southern Rhodesia and South Africa. This was followed by the conference on Food and Nutrition in Africa held at Dchang in French Cameroons in October, 1949.

Also in October, 1949, an African Regional Scientific Conference was held at Johannesburg. The main recommendation which came out of this conference was the setting up of a Scientific Council for Africa south of the Sahara. The idea was put forward by the South African delegation.[31] The broad idea was accepted by all the governments concerned and the Scientific Council for Africa was officially established in November, 1950, when the council held its first meeting in Nairobi. E. B. Worthington, then of the East African High Commission, was

appropriately appointed its first secretary General.[32] The secretariat was set up in the Belgian Congo with headquarters at Cotermansville (now Bukavu).

In 1950, the various governments with interest in Africa south of the Sahara formally organized themselves into an international body known as the Commission for Technical Cooperation for Africa South of the Sahara (CCTA).[33] The duties of the Commission were essentially advisory and consultative. A number of Conferences on a variety of subjects were held under the auspices of both the CCTA and the CSA.

ANGLO-FRENCH COOPERATION IN WEST AFRICA

The Accra Medical Conference held in November, 1946 was a bilateral as well as a regional Conference. It was organized by the French and British governments to discuss medical and health problems of common interest to their territories in West Africa. At the conference information was exchanged on the creation of medical schools for Africans, the training of African nurses and a comparison of the status of British and French African doctors was made. A common service was also initiated for the joint use of anatomo-pathological laboratories. As a result, the following laboratories were accredited for the diagnosis of yellow fever: Dakar, Freetown, Accra, Lagos, Duala, Stanleyville and Brazzaville.[34] Arrangements were also made for the joint preparation and distribution of vaccines.

Agreement was reached on a system of practical cooperation in public health and medical work, especially by mutual efforts against diseases common to border areas. This was to be facilitated by the exchange of visits by the medical officers of French and British territories. Indeed, this proved to be one of the most effective of the recommendations adopted at the Accra Conference. At their meeting of 24 May, 1949, the Colonial Advisory Medical Committee welcomed the considerable advances in cooperative efforts made against diseases in West Africa, largely as a result of personal contacts between officers of the French and British Territories.[35] A look at the practical measures taken as a result of this inter-colonial collaboration reveals very impressive results.

In February, 1947, the DMS Nigeria issued a directive, which, after referring to the main conclusions of the Accra conference, requested Medical Officers to investigate and submit details as to the possibility of arranging interchange of visits. The directive also gave authority to field officers controlling mobile epidemiological units to contact their opposite numbers on the French side in order to synchronize progress so as to ensure that there were no evasions.[36] Following the issue of this directive, various medical officers took steps to contact their colleagues on the French side of the border. For example, the medical officer at Yola made contact with the French medical officer at Garua, when it was agreed to exchange maps showing villages and existing medical posts in their respective areas; to place emergency supplies of drugs at

each others disposal; to communicate to each other the occurrence of infectious diseases; to take concerted action in the case of outbreaks of smallpox, cerebrospinal meningitis; and to control the movement of the population in the presence of such outbreaks.[37]

In April, 1947, Lt. Col. Theraud (Chef du Service Sanitaire, Dahomey), paid a visit to Lagos to discuss epidemiological conditions affecting the Nigeria - Dahomey frontier. Arrangements were made for concerted action against sleeping sickness in the border areas and information in regard to medical services available was exchanged.[38] Similar visits were paid by G. B. Walker, DMS, Nigeria, in 1947 to Dahomey, French Cameroons, Niger, Chad and Dakar. In Dakar he had discussions with Inspector General Peltier. They agreed to immunise against yellow fever and smallpox within a belt of territory 15 miles long by 20 miles wide on each side of the frontier.[39]

In February, 1948, Inspector General Peltier returned Dr. Walker's visit. He was accompanied by Col. Maroud, Major Duvey (Chief of the Niger Medical Service) and Major Lafaye of the French Air Force Medical services. These officers visited Kano where they discussed relapsing fever with the Assistant Director of Medical services, Northern Provinces, and with the local medical officer of health. They also visited Daura in Katsina Province for further discussions with the local medical and administrative authorities. At the end of their visit they were

accompanied by the Asst. DMS, on a visit to Zongo, Rogogo and Babature on the French side of the frontier. During these exchanges methods of control of relapsing fever were compared and correlated.[40]

In the Gold Coast, the DMS , Dr. Turner, visited Lome in French Togoland in 1947 to discuss cooperation there. As a result, there was an exchange of medical maps and a visit from the architect of the new French hospital at Lome to exchange ideas about hospitals and their costs. Generally, liaison was maintained by all medical officers stationed near frontiers and, in particular, by Dr. Morris of the sleeping sickness service. A sleeping sickness team vaccinated a large population between the Ivory Coast frontier and the road from Bomboi Ferry to Wa. This measure was undertaken to protect the Ivory Coast. Along the northern frontier of the Gold Coast an effort was made to vaccinate the whole population within twenty miles of the frontier. Similar measures were taken in the area between Lome and Paline. Here, over half a million vaccinations were given. Of these 19,000 were done by French vaccinators loaned to British teams.[41]

As a follow-up on the problem of the control of sleeping sickness in the Gold Coast and neighbouring French territories, a Conference on preventing the spread of sleeping sickness and other diseases through the agency of

migrant workers was held in Accra on 26 August, 1949. This brought together representatives of the medical and labour services of Ivory Coast, Upper Volta and the Gold Coast. The following conclusions were reached:

i. an employment officer should be established at Bolgatanga

ii. immigrants from Upper Volta who were unable to produce identity cards issued by the French authorities should be refused certificates of registration for employment and instructed to return to their own country.

iii. medical staff should be stationed at Bolgatanga to work in close collaboration with the staff of the labour department.

iv. medical staff should be stationed at the ferry crossings of the Volta River in order to check the condition of immigrants returning to the north.[43]

Although difficult to implement, largely due to the problem of identifying immigrants, the recommendations of this conference went a long way to control the spread of epidemic diseases across the borders. Furthermore, the conference also promoted interdepartmental cooperation, a possibility hardly exploited hitherto.

In Sierra Leone, the medical officer in charge of the Sierra Leone Yaws and Sleeping Sickness Campaign (Dr. Harding), visited Gueckedou, a town in French Guinea, in December, 1946 and met General Peltier. The subjects discussed included the use of pentamidine as a prophylactic against trypanosomiasis and the possibility of teams working simultaneously in contiguous territory on each side of the frontier. However, the shortage of medical staff for the Sierra Leone Medical Department made it impossible to draw up a firm programme on these lines, though arrangements were made to exchange statistical information.[43]

In the Gambia no official visits were made but notes describing the organization of the medical and health departments, together with maps showing the location of the medical units, were forwarded to the Director General of Public Health at Dakar. Unofficial visits were made by an officer of the French Medical Service to Bathurst where discussions with the Medical and Health Department took place on antimalarial measures.

It had been agreed at the Accra conference to hold a further conference in 1948 or 1949 to review progress and give further consideration to cooperation in medical and health questions. In the event, the second Anglo-French Medical cooperation conference was held in Dakar between 16 and 19 May, 1951.[44] Whereas the object of the Accra

Conference had been the establishment of closer medical cooperation between the governments and territories which took part in it, the Dakar Conference was to provide an opportunity for assessing the benefits of this cooperation and of showing the gaps still to be filled.

The Accra Conference recommended, in the first instance, joint action against infectious diseases. Such action was to a large extent successful as has been shown above. What needed to be strengthened was the rapid exchange of information. The conference accordingly recommended inter alia that each DMS should forward direct to the DMS of all the neighbouring territories complete lists of their medical staff, giving their organization in frontier areas, with maps showing their location and size. Furthermore, all transfers and change of personnel and the setting up of new organizations in frontier areas should be similarly notified as they occurred. Any modification in organization should likewise be notified.[45]

These recommendations were well received by the various colonial governments in the region. By March, 1952, for example, a detailed list of all medical facilities in the French territory of Dahomey was available in Ibadan and a similar list, with maps, was sent by the Nigerian Government to the French medical head-quarters at Porto Novo. Lists of medical personnel and their stations in the border areas were also exchanged between the medical authorities in the

French Cameroons and the DMS, Eastern Nigeria. A similar list of personnel, with maps of medical posts near the frontier, was likewise exchanged between the Northern Region DMS and the medical authorities on the French side of the border.[46]

INTER-COLONIAL COLLABORATION AND AFRICAN NUTRITION

In December, 1949, French, British and Belgian nutrition experts metin Paris. One of their objects was to discuss preparations for a Nutrition Conference in Africa. Information was also exchanged on the results of research into African nutritional problems. The Paris conference stressed the need to foster closer liaison in Africa between the research organizations and all local services and institutions having a direct interest in food questions, and also between African research bodies and those in metropolitan countries.[47] As a result of this meeting a Conference on Food and Nutrition in Africa was held at Dchang, French Cameroons, in October, 1949. The conference was attended by twenty-three representatives from Britain, France, Belgium, South Africa and Portugal and from their respective colonies in Africa. Observers from the World Health Organization (WHO) and the Food and Agricultural Organization (FAO) were also present.

This conference was the first of its kind to be held in African and appropriately undertook a general review of the nature and extent of the problem of nutrition in Africa with

particular reference to those aspects shown to be common to all territories. It was unanimously agreed that malnutrition amongst Africans was widespread, affecting all age groups, but more particularly children.[48] Although this assessment was not new, the emphasis the conference placed on malnutrition in children helped to focus the attention of the UN specialised agencies such as WHO and UNICEF (United Nations International Children's Emergency Fund) when they began in the 1950s to direct their interest to medical and health problems in Africa.

One of the subjects on the agenda of the Conference was a proposal put forward by the French for the establishment of some kind of nutritional Organization in Africa.[49] In view of the fact that observers from the FAO had been invited to the Conference, the French, who had made the proposal, considered it essential to maintain some form of contact with the organization. According to them a Nutritional Bureau in Africa would provide the forum for such contact. Indeed, similar organizations, directly under the aegis of the FAO, had been set up in the Far East and Latin America, as a result of recommendations made by the FAO Regional Nutritional Conferences held in the Philippines and Montevideo.

This proposal was considered by the CCTA at the Third Session of the committee held in Lisbon in January, 1951. The proposal for a Nutritional Bureau was to highlight major differences between the colonial powers, particularly France and Britain, as regards their colonies. Whereas the French

Government could take decisions on practically all issues that affected French colonies, British colonial administrations had to be consulted in practically all issues that affected them, and their views, more often than not, prevailed. This was particularly so in 1951, when territories such as Nigeria and the Gold Coast had achieved internal self government. As a result, it was not often that the views of British colonial administrations in West Africa coincided. These territories grew to be very individualistic, so that, at a time when colonial powers in Africa were organizing themselves into a single body, some British territories were increasingly portraying their individual interests.

The French had suggested that the Bureau might be established by internationalising the Field station of the Human Nutrition Research Unit in the Gambia.[50] As far as the British Government was concerned, this was not a practical proposal. The reasons behind their refusal are quite obvious. The latter station was not operated by the Colonial Office or by any of the colonial governments in Africa, but was under the control of the Medical Research Council of the U.K. The Council, as an independent body under Royal Charter, was concerned purely with fundamental research in the medical field; and the field station in the Gambia was operated as an adjunct to the pure research work on nutrition which was carried out by the Human Nutrition Research Unit of the Council in the U.K. The Station was not concerned either with practical nutrition work in the various colonial territories or with the dissemination of

information in the field of applied nutrition. The results of its work in the field of pure research were published in the appropriate scientific journals. For these reasons therefore, not only would the internationalisation of this station have presented great administrative difficulties, but the station would not have been appropriately adapted for the practical purposes which a CCTA Nutritional Bureau would have been designed to serve.

In anycase, the British opposed the establishment of such a bureau. At the end of the Dchang Conference, the Colonial Office had sent out circulars to colonial governments, seeking their views, not only on the conclusions arrived at at the conference but also on the establishment of a Nutritional Bureau in Africa.[51] In their replies, colonial governments, particularly those in British West Africa, pointed out that they were generally alive to the problem of nutrition, and that every effort would be made to overcome it. There were divergent views, however, on the establishment of the Bureau. For the Nigerian Government, the major problem was that of finance:

> Owing to the very large demands on our resources in other fields, this Government has not as yet been in a position to establish a special organization for work on nutritional problems and it is considered that, without such an organization this territory would not be able to make good use of an International African information Bureau on food and nutrition such as suggested. It is regretted, therefore, that this Government does not feel justified in participating in the scheme at the present time.[52]

The Gold Coast Government, on the other hand, would support the scheme as long as the Legislative Council was willing to make the necessary financial contributions. Thus, Governor Alan Burns wrote, 'Subject to the concurrence of the Legislature as regards the provisions of the necessary financial contributions, the establishment of and International African Information Bureau on Food and Nutrition would be acceptable to this Government'.[53]

The Gambia thought they had no use for such a Bureau precisely because the territory did have a Nutrition Research Unit: "This Government is advised that a Nutrition Bureau of the type proposed would be of small value locally, as up to date information on nutritional topics is readily obtainable from the Research organization at work in this territory. In view of the foregoing this Government is most reluctant to commit itself to further expenditure".[54]

The reluctance shown by some British colonial governments to commit themselves to the scheme clearly reveals that the proposal to establish a Nutritional Bureau in Africa was premature, at least as it affected the British West African territories. Indeed, in the whole region there was no elaborate administrative machinery concerned with nutrition;[55] there were very few specialists and the volume of information collected on nutritional work was small. This was due to the fact that the study and application of nutritional science in colonial territories was still in its infancy. Even in the 1950s, the development of nutritional work in individual African territories had not reached a

stage where it could profitably be coordinated on an international basis through the machinery of a permanent bureau. Thus the proposal was abandoned at the tenth meeting of the CCTA held on 10 January, 1951, in Lisbon.[56]

Much had changed since 1946 when the first Anglo-French technical conference was held. A number of specialised agencies of the UN had been set up. Some of these agencies, such as WHO, UNICEF and FAO showed an interest in African health problems. It thus seemed essential to the colonial powers in Africa to present a common front demonstrating that not only were they accountable for the colonies but that they were still in charge. This was one of the reasons behind the reorganization of Colonial Powers in Africa into what could be called a 'Club' - the CCTA. Indeed, one of the objects of the CCTA Secretariat was to maintain relations with international organizations and institutions interested in African problems. Similarly, all technical assistance programmes sponsored by the U.N. agencies to colonial Governments in Africa were negotiated through the CCTA.

THE ROLE OF U.N. SPECIALISED AGENCIES IN MEDICAL AND HEALTH WORK IN BRITISH WEST AFRICA

The Charter of the United Nations, based on the Moscow Declaration of 1943 and the Dumbarton Oaks conference in 1944, was adopted and signed at the U.N. Conference on International Organizations at San Francisco in June, 1945.

The task of bringing into being a specialized health agency with wide powers was given to the Economic and Social Council of the U.N. This was achieved between 1946 and 1948.[57] The decision to create a World Health Organization which would in the words of the Constitution "act as the directing and coordinating authority on international health work",[58] represented an achievement of outstanding significance in the field. Not only was the concept of health given a more positive definition than had been employed by governments; governments were also called upon to be responsible for the health of their citizens. These new emphases are revealed in the constitution of the WHO.[59]

When the WHO was created colonial territories did not automatically become members. The problem of colonial representation on International organizations in the 1940s was relatively new. It assumed significance because the tendency to regard international organizations more and more as a means of solving common problems coincided with a period during which some colonies had made rapid progress on the road to self-government. Some had even reached a stage at which it was essential to encourage them to participate in formulating international policy. Indeed, the experience gathered in the workings of international organizations was an important factor in the training of non-self-governing territories for full self-government.

At the International Health Conference held in New York in June to July, 1946, the Chinese (Taiwan) delegation proposed that the Health Assembly should be empowered to admit as 'associate members' with all rights and privileges except voting and holding office, all such territories "ineligible to separate membership in the U.N., whose areas and populations are large enough, whose health problems are of world concern, and which have indigenous health administration".[60] The U.K. delegation, supported by those of France, Canada, Mexico, New Zealand and South African held the view that the participation of non-self-governing areas should be limited to the regional branches of the organization.[61] This view met with opposition particularly on the question of voting rights. The outcome of the discussion on this matter was Article 47 of the Constitution which recognized associate membership at both the central level and at regional levels with a clause which said that participation would require the consent of the governments responsible for the foreign relations of the territory concerned. The rights granted to associate members in the regions were the same as those granted in the central Assembly; but the Metropolitan power had the right of one vote in each region where it was responsible for non-self-governing territories.[62]

The World Health Organization established Regional organizations to meet the special needs of individual regions.[63] Each Regional organization consisted of a Regional Committee and a Regional Office. Regional

Committees were composed of representatives of member States in the region. Regionalism had the advantage of bringing the organization into close touch with the immediate needs of member countries. The Regional Organization for Africa was established in June, 1951, with headquarters in Brazzaville. The control of communicable diseases was the major problem that the WHO had to tackle in this region.

Two types of assistance were provided by WHO - through its regular budget and through the U.N. Expanded Technical Assistance Programme. In accordance with the rulings of the Technical Assistance Committee of the Economic and Social Council[64] which required governments to enter into agreement with the U.N. specialised agency concerned before qualifying for assistance under the U.N. Expanded Programme, the U.K. Government, on behalf of her colonies, concluded this basic agreement with the chairman of the Technical Assistance Board in June, 1951.[65] Such an agreement was necessary if assistance under the programme was to be provided to non-self-governing territories. A similar agreement was concluded in 1952, with the WHO covering operations under the regular budget.[66] However, a large percentage of the assistance provided by WHO to non-self-governing territories was given under the Technical Assistance Programme.

Technical Assistance was provided with regard to malaria, venereal diseases, tuberculosis, plague, cholera, typhus, schistosomiasis, yellow fever, trachoma and leprosy. Assistance was also given for professional and technical training and education, public health administration, environmental sanitation, nursing, maternal and child health, social and occupational health, antibiotic and insecticide production, the exchange of scientific information and assistance to educational institutions.[67] Assistance was not given in the form of financial grants to local governments; WHO programmes were designed to provide technical services in the form of expert advice and field operations and demonstration teams. They did not cover capital equipment or supplies except insofar as they formed an integral part of the technical service, e.g. equipment required by an expert in carrying out his assignment or essential to the establishment of training and research centres.

The WHO also collaborated with other specialised agencies of the U.N., notably the FAO and UNICEF.[68] in medical and public health work in West Africa. The WHO and UNICEF collaborated in a wide range of projects which directly or indirectly affected children, in schemes specifically intended to benefit maternal and child health, in campaigns against individual diseases such as yaws and

leprosy; and in projects for water supplies, environmental hygiene and staff training. The WHO and the FAO collaborated mainly in the field of nutrition. Requests for assistance were made through the ruling colonial power.

The U.N. specialised agencies began to take an active interest in the health problems of the British colonies in West Africa only in the mid-1950s. The assistance rendered was most obvious in the field of communicable diseases, especially malaria, yaws and leprosy, and also in maternal and child health.

The problem of malaria, was naturally the first to receive the attention of the WHO. Malaria has been the most widespread disease in West Africa. It was the reason why the region had once been known as 'the white man's grave'. In spite of the public health efforts of the medical departments, not much had been achieved in the control of the disease. Early anti-malaria measures had concentrated on the elimination of the mosquito - mainly attack on the larvae. These proved to be very expensive ventures for colonial medical departments. New possibilities for combating malaria were opened in 1939 with the discovery of DDT (a chlorinated hydrocarbon product).[69] With this discovery the attack shifted from the larvae to the adult mosquito.

> The WHO rightly described malaria as, the world's greatest single cause of disablement, it stunts physical and mental development, it hampers the exploitation of natural resources, reduces agricultural production and impairs industry and commerce.[70]

Thus, the fight against malaria became an inherent part of the social and economic action of the U.N. and its specialised agencies.

The WHO anti-malaria programme in African began with the holding of a Malaria Conference. In November 1949, the Second World Health Assembly, recognising that the further development of Africa was desirable, agreed on the need for an anti-malaria policy for Africa. In view of this, the Assembly proposed that the WHO should convene a Malaria Conference in Africa which all the outstanding experts in African malaria, chiefs of malaria services and experts of FAO would participate.[71] The CCTA welcomed the proposal and expressed their desire that the conference be held under the joint auspices of the WHO and the CCTA. Thus arrangements were made by the WHO in agreement with the CCTA to hold a malaria conference in Kampala, Uganda in November, 1950. L.J. Bruce-Chwatt, Senior Malariologist of the Nigeria Malaria Service, was the sole representative of the British West African governments.[72]

The main recommendation of the conference was that colonial Governments responsible for the administration of African territories should initiate experimental schemes for the control of malaria and the eventual eradication of

vector species while WHO provided technical assistance. The conference also proposed that a malaria training course should be organized in Lagos,[73] partly because the territory already possessed a malaria service and some malaria training for subordinate personnel was already in progress.[74] Furthermore, the chief of the malaria service, besides being willing to direct a course of that kind, was a man who was very highly appreciated as a malariologist, through his research work and through his participation in the debates at the conference itself. These recommendations were endorsed by the WHO Expert Committee on Malaria at their forth session held in Kampala from 11 to 16 December, 1950. The Committee then drew up a malaria policy for Africa. This involved sending out malaria control demonstration teams; establishing fellowships for selected personnel; assigning consultants to countries who asked for them and providing lecturers for courses in malariology.[75] The course proposed for Lagos was held in 1952.

The Nigeria Malaria Service had set up its experimental control zone in Ilaro near Lagos in 1950. The Ilaro experiment closed at the end of 1953 with unspectacular results. A new project was started in Western Sokoto, jointly financed by the WHO, UNICEF and the Northern Regional Government. The object was to gather information on the action of insecticides under local conditions, the behaviour of anopheline mosquitoes and the effect of residual spraying on the epidemiology of malaria in tropical Africa. The area of the project, which covered 600 sq miles in Sokoto Province with a population of 125,000, was divided

into three zones, sprayed with D.D.T., B.H.C. and Dieldrin respectively. The malaria indices in the first two zones were more promising than in the third. It was therefore decided to use BHC when the scheme was expanded in 1956. By 1955, however, a population of 121,881 had been protected and 87,240 houses subjected to residual spraying.[76]

Very limited action was taken in the other British West African colonies, principally because of the absence of any malaria service in these territories. Indeed, it was only in 1955 that a WHO assistance was approved for the provision of experts on malaria control in the Gold Coast.[77] Similarly, it was not until late in 1957 that Sir Gordon Covell, a WHO consultant, visited the Gambia at the request of the government. Even then, he was only to review the malaria position and recommend what action might be taken.[78]

The original malaria policy of the WHO involved the indefinite continuation of spraying campaigns. In 1955, however, the Eighth World Health Assembly set the eradication of malaria as the object of anti-malaria activities.[79] A WHO programme for eradication was drawn up for the years 1958-1962. Unfortunately, this did not include tropical Africa as it was thought that local research needed to be intensified in order to find an economic solution. Indeed, this view had been maintained even at the Kampala Conference in 1950, when experts opposed eradication, pointing out that owing to the high endemicity of the disease, adults in the population had gained immunity

through childhood infections. There has been no further attempt at total eradication in tropical Africa. Governments in this region, with very limited resources at their disposal, have resigned themselves to the problem. They have fallen back to directing their resources whereever possible in controlling the disease.

The WHO were more successful in their attempt to combat epidemic diseases. Scientific discoveries were to play a major part in the success story. During the 1940s the medical profession acquired an impressive array of new weapons - antihistamines, new insecticides, and a whole series of antibiotics. International cooperation enabled these discoveries to be brought to the people most in need of them. In British West Africa the major epidemic diseases affected by this cooperation were yaws, leprosy and to a lesser degree tuberculosis.

The WHO was interested in yaws not only because it was a major public health problem in many countries but also because of the availability of penicillin - a weapon of high therapeutic efficacy - to combat the disease. The yaws eradication programme in Nigeria began in 1953. The scheme to control yaws was undertaken jointly with the treatment of venereal diseases. The WHO provided two medical officers, UNICEF voted £150,000 for materials and the Nigerian Government, as well as providing the necessary staff, undertook extensive laboratory investigations.[80] Three centres for field campaigns were selected, one in each Region: Benue and Kabba Provinces in the Northern Region,

Nsukka Division in the Eastern Region, and Ijebu Province in the Western Region. Yaws was found to be hyperendemic and a policy of total mass treatment was adopted. Mass treatment began in 1954. In the Northern Region, 264,983 people were examined and treated with penicillin. Of this number, 10,743 (4.0%) were infectious cases; 35,130 (13.6%) late cases; 141,841 (53.5%) latent cases; 76,264 (28.7%) contacts.[81] In Nsukka Division a total of 383,769 persons were examined and treated with penicillin. Of these 12,221 were infectious cases, 42,553 were late cases and 238,995 were latent cases and contacts.[82].

The Nigeria yaws campaign proved very successful and the Second WHO International Conference on yaws was held at Enugu in November, 1955. During the sessions, delegates made field visits to Nsukka, Awgu and Oji River to inspect initial and follow-up surveys. The major recommendation of the conference concerned a continent-wide attack on yaws and endemic syphilis.[83]

In Sierra Leone the control of endemic diseases was undertaken by the Endemic Disease Control Unit, similar to the Medical field units which were in operation in the Gold Coast and Nigeria. The Unit had conducted sampling surveys of yaws in parts of the Northern Province. In 1954, J. Hackett of WHO visited the unit to give advice on a projected campaign to eradicate of yaws, with penicillin

supplied by UNICEF. The estimated cost of the material supplied by UNICEF for the scheme was $63,000.[84] The scheme took off in 1954. By 1957, 220,000 people in the Northern and South-Eastern Provinces had been examined and treated with penicillin. As in Nigeria the plan of the yaws campaign in Sierra Leone was designed to cover the whole country, the object being the complete elimination of yaws.

In addition to the material aid for the yaws campaign, UNICEF approved a scheme for the supply of equipment for fourteen health centres at Bo and Freetown for nurses, midwives and health visitors. This included a three-ton truck, two hundred midwifery kits for village maternity assistants with charts and 66, 000 lbs of skimmed milk.[85] This assistance was intended for the improvement of facilities for basic child care.

Leprosy was widespread in Nigeria. Here, it was estimated that there were half a million cases of leprosy, of whom half were mothers and children.[86] The care of lepers was long established in Nigeria and by the 1950s large areas had come under control. In 1953 UNICEF agreed to assist the scheme for leprosy control. Nigeria received $93,000 to be used mainly to purchase drugs. UNICEF also undertook to give assistance in improving environmental conditions, particularly water supplies, at segregation villages and settlements.[87] In the Northern Region leprosy control was a combined undertaking of WHO, UNICEF and the

Northern Regional Government. Here, the attack was centred on the out-patient clinics attached to the Native Administration dispensaries. By September, 1955, there were 63,503 patients under treatment in out-patient clinics, segregation villages and settlements.[88]

The enthusiasm shown by the Nigerian Government in controlling leprosy was lacking in the other British West African Colonies. Indeed, it was only in 1958 that a WHO leprosy scheme was initiated in Sierra Leone.

Action on tuberculosis did not begin until the discovery of Bacille-Calmette-Guerin (B.C.G). In West Africa pulmonary tuberculosis was an endemic problem due to overcrowding in the urban centres and in the cities. Yet, the real extent of the disease remained unknown. Thus the initial assistance provided by the WHO in this field was the provision of Tuberculosis Survey Teams to carry out epidemiological surveys, with a view to providing the factual basis for the suitability of mass B.C.G. campaigns.

In 1958 the WHO launched its attack on smallpox. This, like the campaign against yaws was very successful, but a proper consideration of this subject would take us beyond the period covered in this thesis.

INTERNATIONAL COOPERATION ON NUTRITION

The first move towards international cooperation on food and nutrition was a conference convened by the U.S.A. on Food and Agriculture at Hot Springs, Virginia, in 1943. This noted the vast extent of the world's nutrition problem and the need to determine intermediate objectives for each country according to its particular circumstances and special needs. International collaboration was essential, and securing it would be the task of the proposed United Nations Food and Agricultural Organization (FAO). Sound food and nutritional policies involved co-operation between public health and agriculture and required the guidance of a central authority. Therefore governments should undertake to establish national nutrition organizations, if they did not already exist, such organizations to be provided with adequate personnel, funds, facilities and authority. The conference also noted that requirements in terms of appropriate foods could be readily drawn up to suit the tastes and resources of different peoples. On the other side of the picture, reasonably accurate statistics of food supply and production were required, in order to be able to draw a balance sheet.[89] Finally, the conference concluded that "the goal of freedom from want of food, suitable and adequate for the health and strength of all peoples could be achieved".[90]

The publication of the Resolutions and Section Reports of the Hot Springs Conference appeared to be a suitable occasion to emphasise the need for an active coordinating

body in planning nutrition policy. In the light of the resolutions of the conference, among the most important tasks of such a body would be to define objectives, immediate and long term, translate them in terms of foodstuffs appropriate to the environment and habits of the population groups concerned, and consider their implications in relation to supplies, resources and trade. The conference did not suggest that the implementation of a comprehensive nutrition policy of this kind was immediately possible but it considered that the time had come to begin to apply the lessons of the war to questions of postwar nutritional development and to map out the way to the attainment of a food policy based on physiological needs at the level agreed as an intermediate objective. This conference was the forerunner of the FAO which was formally organized at the Quebec Conference, Canada, in 1945. At the Quebec conference, it was agreed that the FAO would limit its activities to collecting statistics on food production and distribution, promote research and give technical assistance to food deficit countries.

This had several implications for the British West African Countries. Although they had been encouraged to produce more food during the war, the object was essentially to satisfy the immediate war effort. To coordinate information such as that required by the FAO would require

a nutritional organization but there was none in British West Africa.[91] The Colonial Office proposed arrangements for training and more research on nutrition - one of the reasons why the office cooperated with the MRC Nutrition Unit in the Gambia.[92]

At the Second Annual Conference of the FAO held in Copenhagen in September, 1946, Lord Boyd Orr, the Director General of FAO, proposed the setting up of a World Food Board. The Board as conceived by the Director General aimed to create a world which would abolish the scandal of want in the midst of plenty.[93] The proposal was discussed and accepted by the conference. Two main objectives were agreed upon at Copenhagen:

a. Development and organization of production, distribution and utilization of basic foods to provide diets on a health standard for the people of all countries;

b. Stabilise agricultural prices at levels fair to producers and consumers alike.[94]

The conference set up a Preparatory Commission with the task of making specific recommendations for achieving these two objectives. The Commission met in Washington on October 28, 1946 and completed its report on January 24, 1947; it was issued in the U.K. as a White paper.[95]

Under the new proposals the World Food Board became a Council - with advisory rather than complete executive powers. Stocks of food were to remain in national instead of international hands. Reserve stocks of food were to act as buffers against both scarcity and surplus with the aim of keeping prices steady. But on the recommendation of the Council, they could also be allocated at special rates to needy countries when required. The main emphasis was on self-help on the part of governments, especially those in less developed areas who wished to secure agricultural and nutritional improvement.[96]

The proposals for a World Food Board with powerful executive powers was strongly opposed by Britain and the United States. The British Government was determined to resist any economic change which would threaten not only their financial interests but their political power as well. The traditional British preference was for cheap imported food, allowing both low wages and better profits both from industrial exports and from the shipping required to import food from the colonies and other countries. While the United Nations was discussing the proposals in October 1947, the following telegram was sent by the Foreign Office to the U.K. Delegation:

> we are not clear what the Indian Delegation may have in mind. It may be the familiar but unpractical point about distributing food where it is needed and not according to ability to pay. If you can tactfully kill a resolution of this sort so much the better but we should not be unduly worried.[97]

Indeed there was no need for the British Government to be unduly worried. The Indian Delegation had in fact decided not to move a resolution, since it would not have necessarily been followed by practical results. Rather, on October 10, the Delegate sarcastically confined himself to stating that, 'the FAO was a 'torch of hope' to all those who looked to it for measures for ensuring maximum production of bread grain, fertilisers, agricultural machinery etc'.[98]
He added the hope that, 'present controls by Governments over distribution and consumption of food would be continued and that controls would be introduced where they did not now exist'.[99]

As if in response to this comment, in February, 1948, the British Parliament passed the Overseas Resources Development Act. This provided for the establishment of a Colonial Development Corporation (CDC) charged with duties for securing development in colonial territories and for the establishment of an Overseas Food Corporation (OFC) charged with duties for securing the production or processing of foodstuffs or other products in places outside the U.K. and the marketing of the products and other matters connected with it.[100]

In the case of the Overseas Food Corporation, the powers of the Colonial Secretary were all negative except where it was stated that the Corporation might not formulate or carry out any project in places outside the U.K. unless invited to do so by the Colonial Secretary. All other powers were

invested in the hands of the British Minister of Food. The Colonial Secretary had no power to control the progress of operations or the staff of the corporation whether in the U.K. or in the colonies nor had the governors concerned. As for colonial governments of the territories in which the Corporation Operated they were bypassed; their only concern was to be 'appropriately' consulted before an undertaking was established.[101] The implication of this was that neither the Colonial Secretary nor colonial governments had the power to reduce any requirements, to query their necessity, to query the material produced, nor any power to give preference. The result was the entrenchment of the traditional policy of encouraging colonial territories to produce cash crops for export. Indeed the initial aim of setting up these Corporations was to produce groundnuts.

The killing of the resolution which would have created a World Food Board including the colonial territories meant that the problem of nutrition in these territories was reduced to the level of technical conferences. Thus prevailed the view of the British Government in the 1930s that colonial nutrition was essentially a technical problem.[102]

In 1950, a joint FAO/WHO Expert conference on Nutrition was held. At the conference it was agreed that,

> available evidence indicates that serious problems of nutrition exist in many parts of Africa and that there is an urgent need both for further research on these problems and for the further development of practical programmes to raise levels of nutrition.[103]

Like the British colonial governments the WHO and the FAO also found refuge in the policy of more research. The emphasis and concentration on nutrition research was obviously a way of escape from the more difficult task of outlining measures for increasing food supply to abolish hunger. In one of the replies sent to the Colonial Office on the 1943 Hot Spring Conference, the Acting Director of Medical Services, Gold Coast, stated that 'a successful nutritional policy is dependent on a drastic increase in wages in the Gold Coast and in other West African Colonies.[104] The problem therefore revolved around raising the standard of living of the people.

Much was achieved in the campaigns against specific diseases in West Africa. The expanded programme of technical assistance enabled international organizations to provide expert advice, assistance and training facilities in a very wide field, its object being directed towards helping governments to help themselves, for without the initiative of recipient governments no assistance was rendered. In spite of this success however, the problem of colonial nutrition remained largely unsolved. The reasons for this are not far-fetched. First, European powers and the United States did not favour international cooperation in this

direction. In the 1940s and 1950s, they had no serious opposition whatsoever in the International organizations as they were to have in the 1960s when a large number of ex-colonies gained independence and were admitted as full members of these organizations. Secondly, the problem of nutrition was not regarded as a priority by African nationalists. Indeed what was important to them was the attainment of political independence and this was what they fought for.

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1. On the history of International collaboration in public health see, e.g., Neville Goodman, International Health Organizations and their work (London, 1971); Fraser Brockington World Health (Edinburgh, 1975); Norman Howard-Jones, The Scientific Background of the International Sanitary Conventions, 1851-1938 (Geneva, 1975); Idem. International Public Health between the two world wars: The Organizational Problems (Geneva, 1978).

2. Goodman, op. cit. p.53.

3. At its inception the office had the following membership: Great Britain and Ireland, Portugal, Russia, Switzerland, Belgium, Spain, U.S.A., France, Brazil, Italy, Egypt and the Netherlands.

4. Quoted in Brockington, World Health, op. cit. p. 147.

5. E. B. Worthington, Science in Africa (London, 1938), p. 463.

6. Howard - Jones, International Public Health Between the Two Wars ... op. cit. ch. IV

7. Cmd. 4863 (1935) International sanitary convention for Aerial Navigation held at the Hague, April, 1933.

8. The South African proposals were relayed via the League of Nations to the foreign Office and subsequently to the C.O. See Albert Dufour Ferience (Ag. Sec. Gen. of the League of Nations) dated 27/7/32 to F.O. in CO847/1/28020 (1932): African Health Conference.

9. CO849/1/28020 (1932): African Health Conference; E. B. Worthington, Science in Africa: A Review of Scientific research relating to Tropical and Southern African (London: OUP, 1938), pp. 464-465.

10. CO323/1218/10570 (1933) Plague in Africa.

11. CO323/1331/3418/2 (1935) Sanitary control of Aircraft convention: African Infectious Diseases outbreaks and diseases affected aerodromes, Direct notification of international Office.

12. The Report of this conference was published by the League of Nations. See Report of the Pan-African Health Conference held at Johannesberg Quarterly Bulletin of the League of Nations V (1936) pp. 198-209; See also CO847/4/7/47008 (1935): Pan-African Health Conference coordination of health work in Africa.

13. See CO859/14/1/3521 (1939) Pan-African Health Conference-Nairobi, 1940.

14. This South African ambition was never abandoned as the proposal to establish the Committee for Technical Cooperation for Africa South of the Sahara (CCTA) was put forward by them.

15. The following files have information on these Conferences: CO323/1464/3461/2 (1937): Leprosy International Congress - Cairo; CO323/1465/3466/2 (1937): Tuberculosis: Care and after care; CO323/1465/3508 (1937): International Congress of Tropical Medicine and Malaria; CO323/1465/3503 (1937) Maternity and Child Welfare Conference.

16. See CO859/111/1/12486 (1944) Proposed Emergency Sanitary convention,

17. See Oliver Stanley to Colonial Governments dated 10/8/44 in Ibid.

18. Goodman, opp. cit. p.190.

19. Report on the First Session of the Expert Committee on International Quarantine (Geneva, Nov. 1948) in Official Records of WHO no. 19, PP. 5-17; On the subject of the revision of the International Sanitary Convention See also CO859/217/5/12486/10 (1949-50_ WHO: International Sanitary Regulations.

20. Official Records of WHO "WHO Expert Committee on International Epidemiology and Quarantine" (Geneva, 1/10/49).

21. Secretary of State to Colonial Governments dated 2/11/51 in CO859/217/3/12480/45 (1951-52): WHO Regulations for the Control of insect vectors of disease on international traffic.

22. See p. 5

23. See P.S. Selwyn-Clarke, Report of the Yellow Fever Conference held at Dakar (Accra, 1927).

24. W. B. Johnson, Notes upon a journey through certain Belgian, French and British West African Dependencies to observe general medical organization and methods of hypanosomiasis control (Lagos, 1931).

25. See for example, Andrew Roberts, "The Imperial Mind" pp. 24-76 in A. D. Roberts (ed.) The Cambridge History of Africa Vol. 7 from 1905 to 1940 (Cambridge 1986), pp. 58-9, 76.

26. On cooperation in the area of production and supply see Lee and Petter The Colonial Office, War and Development Policy (London, 1982); Lee, "Forward Thinking" and war: The Colonial Office during the 1940s" Journal of Imperial and Commonwealth History, VI, (Oct. 1977), pp. 64 - 79.

27. CO927/40/1/28050/1 (1948): Research Collaboration with France.

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29. Cmd 7433 The Colonial Empire (1947-48), p. 88.

30. The Programme drawn up could be found in CO927/40/1/28050/1 (1948), opp. cit.

31. CO927/124/7/28021/65/A (1950): Recommendations arising from the African Regional Scientific Conference.

32. E. B. Worthington The Ecological Century: A Personal Appraisal (Oxford: 1983), ch. 8.

33. On the establishment of the CCTA see CO927/126/1/28021/65/D (1950), opp. cit.; CO927/125/3/28021/65/A (1952): Regional Coordination of research: CCTA.

34. CO859/106/3/12423 (1946) Anglo-French Medical Conference, Accra, November, 1946.

35. CO859/152/5/12402/7 (1949) CAMC: Agenda and minutes.

36. Ibadan National Archives (INA) CSO 26/43161/S/4 Vol. III (1947-50), Anglo-French Medical Conference.

37. Ibid.

38. Ibid.

39. "Cooperation in Africa with the French", Note by the C.O. dated 11/6/47 in CO859/152/5/12402/7 (1949), op. cit.

40. (INA) CSO 26/43161/S.4 Vol III, opp. cit.

41. See Savingram, Chief Secretary, West African Council, to the Colonial Secretary, 3/8/48 in Ibid.

42. Reported in Togoland Annual Report ((1949), p. 18.

43. See Savingram, Chief Secretary to Secretary of State, op. cit.

44. CO859/211/3/12423 (1951) Recommendations of the Medical cooperation conference, Dakar.

45. Ibid

46. On the joint action taken at international boundaries to control infectious diseases see CO859/211/3/12423 (1952): Report on Action taken pursuant to the agreed conclusions of the Anglo-French Medical Conference held in Accra, 1946.

47. CO859/230/1/12610/16 (1949-50): International collaboration on African Nutrition.

48. See Report of the Dchang Conference in Ibid.

49. CO859/230/12610/16/1 (1949-50) International Collaboration in African Nutrition. Proposals for a Permanent Nutrition Bureau in Africa.

50. CO859/230/4/12610/16 (1951): International Collaboration in African Nutrition. Proposals for a Permanent Nutrition Bureau in Africa.

51. CO859/230/2/12610/16 (1951) International Collaboration in African Nutrition.

52. Replies in CO859/230/3/12610/16/1 (1949-50) Proposals for a permanent Nutrition Bureau in Africa.

53. A. Burns to C. O., 27/11/50 in Ibid.

54. Gambia to C.O. in Ibid.

55. In British West Africa there were no nutritional organizations worth the name. A number of nutritional Committees had been set up in the late 1930s when Colonial nutrition became an issue of Colonial policy. In the early 1940s, particularly with the creation of the Social Services

department in 1939 and the subsequent transfer of nutritional matters to this department, many of the nutritional committees were reorganized into welfare committees. Nutrition Committees thus ceased to exist. Turning Nutrition Committees into Welfare Committees marked the death and burial of nutrition work in West Africa.

56. Third Session of the CCTA, Lisbon in CO859/230/4/12610/16/1 (1951), opp. cit.

57. CO859/110/2/12480 (1946) Proposed International Health Organization PT.I; CO859/110/3/12480 (1946) PT. II, International Health Organization.

58. Official Records of WHO No. 2 (June-July, 1946); See also CO859/110/4/12480 PT. III (1946) International Health Conference.

59. See Final Acts of the International Health Conference held in New York from 19 June to 22 July, 1946 in CO859/110/4/12450. opp. cit.

60. "Associate Membership" in Official Records of WHO No. 2 (June - July, 1946), pp. 18 - 19.

61. Ibid.

62. CO859/155/6/12480/15 (1949) WHO: Associate Membership PT. III.

63. Six regional organizations were established: South East Asia, Eastern Meditarrean and The Americas in 1949; Europe, Africa and Western Pacific in 1951.

64. The Economic and Social Council was responsible for coordinating the work of the specialised agencies with that of the United Nations.

65. CO859/217/1/12480/44 (1951) WHO: Conclusions and negotiations of Agreement in connection with technical assistance Schemes.

66. Agreement in CO859/217/2/12480 (1952) WHO and the UN Expanded Technical Assistance programme.

67. Secretary of State to colonial governments, dated 4/3/52 in CO859/217/2/12480 (1952), opp. cit.

68. UNICEF was not a specialised agency of the UN and did not operate any funds under the Expanded Programme of Technical Assistance. It is a body supported by the voluntary contributions of Governments and individuals which was set up by the General Assembly in 1946 as a successor to UNRRA to care for necessitous children and expectant nursing mothers in the war devastated countries. In 1950, The General Assembly decided to extend the life of UNICEF for another three years and enlarged its scope to include territories other than those devastated by the war. At its Session in May, 1951, the Executive Board of UNICEF, for the first time expressed an interest in developing programmes in Africa.

69. D.D.T. was discovered by Paul Muller (a German).

70. WHO Pamphlet "Malaria eradication: a Plea for health" (Geneva, 1958), p.5.

71. "Malaria conference in Equatorial Africa" WHO (Office of the Director - General) to Under Secretary of State for the Colonies dated 23/11/49 in CO859/21612/12480/27 (1950) WHO: Anti-malaria programmes.

72. It was the wish of the Directors of Medical Services, Nigeria, Gold Coast, Sierra Leone and the Gambia, that Bruce-Chwatt should represent them. See CO859/2/6/3/12480/27 (1950) PT.II WHO: Anti-malaria programme.

73. See CO859/216/4/12480/27 (1951) WHO: anti-malaria programme: See also WHO Technical Report Series No. 38 "Malaria Conference in Equatorial Africa" (Geneva, April, 1951).

74. See Chapter 6

75. WHO Technical Report Series No. 39 "Expert Committee on Malaria" Report on the fourth Session (Geneva, April, 1951).

76. Figures given in Annual Report for Nigeria for the year 1955. p. 98.

77. Togoland Annual Report (1955), p. 4.

78. The Gambia, Annual Report for the years 1956 and 1957, p. 46.

79. The eradication programme became very urgent because the mosquito vectors were developing resistance to commonly used insecticides in different areas. In 1951 for example,

it was announced that the malaria mosquito had ceased to die from D.D.T. in Greece.

80. Annual Report for Nigeria (1953), p. 72.

81. Figures compiled from Nigeria, Annual Report for the Year 1954, p 118.

82. Albert Zahra "Yaws eradication Campaign in Nsukka Division, Eastern Nigeria: a preliminary Review" Bulletin of WHO 15, (1956), p. 911.

83. Nigeria, Annual Report (1955), p. 114.

84. Sierra Leone, Annual Report (1955), p. 58.

85. Sierra Leone, Annual Report (1957), p. 68.

86. Sir Charles Ward "United Nations work in Africa" African Affairs, Vol. 54, (1955), p. 211.

87. Nigeria Annual Report,1953), p. 72.

88. Nigeria, Annual Report, (1955), p. 112.

89. CO859/68/6/12620 (1943) United Nations Conference on Food and Agriculture.

90. United Nations Conference on Food and Agriculture (Hot Springs, Virginia, May 18th - June 3rd, 1943), P. 11.

91. See note 55 above

92. CO859/68/6/12620 (1943), op. cit.

93. His dreams of a World Food Board and how they were

destroyed by the selfish interests of Britain and the United States are recorded in his memoirs, As I Recall, (London, 1966) See especially Part IV.

94. CO852/803/2 (1947) Proposals for World Food Board - FAO.

95. Cmd. 7031 (Jan. 1947) F.A.O. of the U.N. Report of the Preparatory Commission on World Food proposals.

96. Ibid. See especially Chapters 2 and 3.

97. From F.O. to the U.K. Delegation to the U.N. Oct. 9, 1947 in CO852/803/2 (1947) op. cit.

98. These comments were transmitted by the U.K. Delegation to the F.O. in a telegram dated 13/10/47 in Ibid.

99. Ibid.

100. Overseas Resources Development Act February 11, 1948 in CO852/801/4 (1948) Policy Towards Colonial Development Corporation and overseas Food Corporation.

101. Ibid.

102. See for example Michael Worboys "Science and British Colonial Imperialism" (Ph.D. thesis, University of Sussex, 1979), especially ch. 8.

103. WHO: Technical Report Series No. 16 (1950): Joint FAO/WHO Expert Committee on Nutrition (Geneva, June, 1950).

104. CO859/117/10/12637 (1945) Summary of Replies to Hot Springs Circular dated 4/2/44.

CHAPTER EIGHT

CONCLUSION

Throughout the study our focus has been directed towards the individual strands which collectively made up medical and health policies in British West Africa. Indeed, the detailed documentation of the specific developments and shifts in policy are of necessity, one of the major objectives of what is in fact the first thesis on this topic to be based on official records. With this task accomplished it remains to draw these strands together.

The study began by looking at medical and health policies in British West Africa in the inter-war years. These were the complacent years when policy was ad hoc and based on expediency. By the close of the inter-war period, the Colonial Office had became acutely aware of the need to rationalise its policy not only in West Africa but in the whole of the Colonial Empire. The liberal or paternalistic (as some scholars would prefer to call it) policy adopted by the imperial government in the late 1930s culminated in the passing of the C.D and W Act in 1940. The Act for the first time made funds available for social Welfare and economic development in the colonies. Before the 1940 Act was passed, however, colonial governments were supposed to be financially self-supporting. From their local revenues they provided basic stimuli for both economic and social development.

The initial policy of health and medicine in British West Africa was the provision of health care facilities for Europeans and other government officials. However, stimulated by wide-spread epidemics in the 1920s, colonial authorities organised large scale hospital programmes as well as sanitary reforms which would benefit the indigenous population as well. By the end of the 1920s, the medical services had become reorientated to treat Africans. The services provided during this initial period were concentrated in urban areas.

By the end of the 1920s, it had become also clear to colonial governments in British West Africa that if health care facilities were to be extended as far as possible, then local administrations would have to play an increasing role in providing these services. In the late 1920s, following the implementation of the policy of Indirect Rule, a number of Local Administrations had been established, particularly in Nigeria. These bodies performed administrative, judicial and financial functions. Thus from their local revenue, they provided basic health care facilities, especially the establishment and staffing of dispensaries and child welfare centres in the rural areas.

This development was halted as a result of the world economic slump of the late 1920s and early 1930s. Meanwhile, however, the Imperial Government passed the CDA of 1929. Although the primary object of the Act was to alleviate unemployment in Britain, the promotion of public health was among the objects by which the purpose of the Act

might be achieved. The Nigerian Government, exercising its supervisory role over the Local Administrations, was able to put through successful applications for assistance from the CDF. The funds made available were used to promote public health in the rural areas. Thus by the end of the 1930s, there was at least one dispensary in each Province of Nigeria. The existence of these was essential for the success of campaigns against such epidemic diseases as yaws and sleeping sickness.

The story was different in the other British West African Territories. In the Gold Coast, Sierra Leone and The Gambia, where Local Government and its accompanying institutions were not established until the late 1930s and early 1940s social services such as the provision of medical and health facilities were virtually non-existent outside the coastal areas in the inter-war years. Hence the unequal distribution of both curative and preventive services over various parts of these Territories.

In the 1930s, there were increasing metropolitan initiatives in colonial affairs and the general official attitude towards Colonial development began to emphasise social development. This interest was aroused as a result of a series of Reports on labour conditions in the Colonial Empire, the publication in 1938 of Lord Hailey's African Survey and the publication of the Report on Nutrition in the Colonial Empire in 1939. Thus it was recognized that if resources from within the colonial territories were

inadequate for political, economic and social development, then public revenue from Britain must be substituted. This change of attitude by the Imperial Government culminated in the passing of the CD and W Act in 1940. The Act encouraged colonial governments to take the initiative in planning the development of their various territories. As a result, long-term development plans became a common feature of colonial administration.

The CD and W Act and subsequent amendments for the first time provided funds from British Treasury for the development of both economic and social resources of the colonial territories. The development plans which the Acts called for represented the result of a joint attempt to appraise - probably for the first time - the prospects and potentialities of each individual Territory and to devise the most effective allocation of the resources available for development.

The objectives of public health development plans were the expansion of medical and health care facilities to provide a better coverage of the population by a programme for constructing new institutions, and the extension and improvement of existing ones; the provision of qualified staff to service these facilities by good training programmes; reduction in maternal and child welfare mortality by the strengthening and extension of maternal and child welfare services and the attack on major communicable diseases.

The revised Act of 1945 expressed the war-time shift of interest from social services to economic development. However, the development plans drawn up from 1946 clearly showed the ever-present interest in the improvement of social services. By 1950, forty per cent of all commitments for the use of the Funds went towards educational and health services. The reason for this state of affairs can be explained - colonial governments were aware that even as late as 1950, the issue was not so much that of development as of welfare.

The establishment of British rule in West Africa and the subsequent introduction of rudimentary medical and health services also stimulated research in tropical diseases. To demonstrate their interest on medical research, the Colonial Office instituted first, the TDRF with an Advisory Committee and secondly, the CMRC. The establishment of the CMRC in 1927 stands out as a dramatic attempt to bring expert scientific attention to the critical problems of colonial medical research in the inter-war years.

In the British West African territories, a number of research institutions were established but these provided in the main, routine laboratory services. However, the institutionalisation of medical research in the early years of Colonial rule meant that research remained an integral part of Colonial administration. This took the form of

administration, clinical work and demonstrations. Hence colonial medical officers were seen as agents for the diffusion of scientific knowledge and experimentation in new techniques, particularly therapeutic drugs.

During the inter-war years, coordination in the planning of medical research was conspicuously absent. Consequently, there was a division between research conducted in the colonies and sponsored by colonial governments and Colonial Office initiatives which involved attempts at the central organisation of medical research. However, whether in the colonial territories or in London, a common problem that faced medical research, not only in West Africa but in the whole of the Colonial Empire, was the lack of financial resources to sponsor research projects and the difficulty of obtaining qualified research workers. The CD and W Act of 1940 was also designed to address these problems.

In 1942 the Colonial Research Committee was formed with powers to create a Colonial Research Service and subject sub-committees. The Colonial Medical Research Committee, set up in 1945, to advise on how best medical research could be conducted in the Colonial Empire, exerted considerable influence on colonial medical research policy. The committee, which included several members of the Medical Research Council, naturally favoured fundamental research, hence greater control of policy by the MRC. The domination of the CMRC by members of the MRC resulted in huge sums of money being voted for individuals, who, more often than

not, were members of the MRC. Naturally, such individuals initiated research schemes in areas in which they had vested interest and not necessarily research schemes which were of benefit to colonial peoples. However, because of the low levels of development of the colonies, fundamental research was considered by colonial governments as not relevant to the immediate needs of British West Africa. Hence the establishment in 1953 of a research organization with emphasis an applied research.

The reorientation of medical policy in favour of the indigenous population also resulted in an increased demand for European Medical Officers and European nurses. This change of policy coincided with a period of the absence of suitably qualified personnel. By the mid 1920s, recruitment had greatly improved but this did not last long as a result of the economic depression. During this period most colonial governments placed embargoes on recruitment. This move had long-term repercussions on the colonies.

The responsibility of the Colonial Office to recruit medical officers for the colonies raised several issues. Firstly, the establishment of three schools of tropical medicine in Britain at the time for the training of Colonial Office doctors proved to be unnecessary. Since the average annual recruitment figures for the entire Colonial Medical Services between 1925 and 1937 for example, did not exceed 66, and that the London School of Hygiene and Tropical Medicine organized three courses in a year for Colonial doctors, it came to be realised that there was no need of

schools other than that in London. In any case , the Colonial Office was not bound to give official recognition to the others. The official recognition given to these institutions by the Colonial Office, as would be expected, resulted in great rivalry for financial resources between them.

Secondly, since Colonial Office officials were neither willing nor able to recruit in many qualified Medical Officers of Health, there was apparent concentration on curative medicine to the neglect of preventive medicine. Thus, the colonial medical policy which emphasised curative medicine was reflected in appointments to the CMS.

Several measures were adopted by the Colonial Office in an attempt to improve recruitment for the CMS. The first of these was the appointment of a Chief Medical Adviser to the Colonial Office in 1926. It was found necessary to make this appointment largely as a result of the powerlessness and ineffectiveness of the CAMSC. The greatest achievement of this post was the establishment of personal contact with the Deans of British Medical Schools and the British Medical Association. Although this personal contact went a long way to stimulate interest in the service, it hardly brought any drastic change in recruitment prospects.

Secondly in 1934, the Colonial Medical Services were unified into a single service. The primary object of unification was to attract more and better candidates to the

service. However, prospective candidates began to compare the CMS with other Medical Services such as the Indian Medical Service and the Royal Army Medical Corps. Conditions of service in these services were much more attractive than those in the CMS. Again one could not talk of the Colonial Empire in the same way as India; this was a single political entity. Whereas the Colonial Empire was made up of numerous colonial governments, with different conditions and terms of service. Indeed, it could well be said that, the unification of the Colonial Medical Services never really took place.

It was not always easy for the Colonial Office to find suitable officers for the CMS. This problem was made no easier by the policy which emphasised that medical candidates must be of pure British descent. After the second world war, broke out, however, several factors came into play that changed the entire policy of recruitment for the CMS. After the war there was a general move towards Africanising the public services in West Africa. There were several reasons for this. First, the CD and W Act provided funds for development and welfare schemes. These schemes could not be adequately executed without the necessary personnel. Secondly, as a result of rapid constitutional advancement in some colonial territories in West Africa, particularly the Gold Coast and Nigeria, there was an increasing demand, not only for the employment of more Africans but also for their appointment to senior posts in the various colonial public services. Thirdly, the creation of the National Health Service in Britain in 1948, for the

first time offered careers to doctors and nurses carrying pensions on retirement. Consequently, a pensionable career in the CMS was no longer as attractive as it used to be. Thus, the only solution to recruitment seemed to be the establishment of training schools in the colonies and the employment of locally trained African doctors and nurses.

Upto 1956 the Colonial Office still had a direct responsibility for ensuring that the public services of all territories comprising the Colonial Empire were adequately staffed and that its organization was geared to the proper discharge of that responsibility. From 1957 onwards, in one territory after another, the transfer of power renounced this responsibility entirely from the Colonial Office to the independent governments. As a result, the machinery in the Colonial Office responsible for the discharge of these duties was gradually dismantled. The devolution of power resulted in the transfer of responsibility from the Colonial Office to the Department of Technical Cooperation in 1961 (the Department of Technical Cooperation became the Ministry of Overseas Development in 1964), the inheritor of the advisers and the principal subject departments. Thereafter, the only formal obligation on the British Government was to ensure a fair deal for the civil servants whom it had recruited but who were still in the service of the new independent states.

An important feature of the post WWII period was the development of international Cooperation which culminated in

the establishment of the United Nations in 1945. By the early 1950s, U.N Specialised Agencies such as the WHO, UNICEF and FAO had begun to show interest in solving African health problems. Much was achieved in the campaigns against specific diseases in West Africa but the problem of Colonial nutrition remained largely unsolved, chiefly because European powers and the United States did not favour cooperation in this direction. In the 1940s and 1950s, colonial territories had little or no power to influence international policy to their favour and in any case, the problem of nutrition was not regarded as a priority by nationalist leaders. Indeed, the main emphasis, understandably enough, was on attacking colonialism and there was a tendency to assume that the end of colonial rule would itself be sufficient to solve basic economic and social problems.

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C0583 : Nigeria, Original Correspondence

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APPENDIX A

PROVISION OF MEDICAL INSTITUTIONS UNDER NIGERIA'S FIRST TEN-YEAR DEVELOPMENT PLAN

No	Province	approxi-mate. pop	Hospital Centres	Class of Hos-pital.	Beds Exis-ting.	Beds pro-posed.	In-creased
1	Adamawa	700,000	Yola	B	36	116	
			Jalingo	C	-	48	48
			Mubi	C	-	48	48
2	Bauchi	1,000,000	Bauchi	B	56	154	98
			Azare	C	43	63	20
			Gombe	C	-	90	90
			Barazo	C	-	48	48
3	Benue	1,000,000	Markurdi	B	79	189	110
			Keffi	C	-	60	60
			Oturkpo	C	-	60	60
			Gboko	C	-	60	60
			Wukari	C	40	90	50
4	Bornu	1,200,000	Maiduguri	A	89	199	110
			Bill	C	-	48	48
			Dumboa	C	-	36	36
			Geidam	C	-	48	48
			Mongunu	C	-	36	36
			Nguru	C	-	48	48
			Bama	C	-	48	48
			Potiskum	C	-	48	48

5	Ilorin	600,000	Ilorin	B	46	180	134
			Kaiama	C	–	60	60
			Offa	C	30	90	60
			Lafiagi	C	–	60	60
6	Kabba	500,000	Lokoja	B	43	110	67
			Idah	C	40	40	–
			Ayangba	C	–	48	48
			Kabba-Okene	C	–	48	48
7	Kano	2,500,000	Kano	A	332	480	148
			Hadejia	C	36	90	54
			Kazaure	C	–	90	90
			Gomeh	C	–	90	90
			Birin-Kuda	C	–	90	90
8	Katsina	1,000,000	Katsina	A	244	300	56
			Daura	C	–	60	60
			Malumfashi	C	–	90	90
9	Niger	500,000	Minna	B	34	114	80
			Bida	B	70	120	50
			Abuja	C	–	60	60
			Kotangora	C	–	60	60
			Zuru	C	–	60	60
10	Plateau	600,000	Jos	A	122	232	110
			Ladi	C	62	122	60
			Pankshin	C	62	92	30
			Kafanchan	C	62	92	30
			Wamba	C	–	60	60
			Shandam	C	–	60	60

11	Sokoto	2,000,000	Sokoto	A	116	360	244
			Kebbi	C	10	90	80
			Gusau	C	25	90	65
			Yelwa	C	–	60	60
			Argungu	C	–	60	60
12	Zaria	500,000	Zaria	B	155	175	20
			Kaduna	A	134	184	50
			Zonkwa	C	–	6	60
13	Abeokuta	500,000	Abeokuta	A	96	296	200
			Ilaro	C	1	90	90
14	Benin	500,000	Benin	B	35	120	85
			Asaba	C	–	60	60
			Okpoma	C	–	60	60
			Agbor	C	29	59	30
15	Calabar	1,000,000	Calabar	A	132	222	90
			Eket	C	–	36	36
			Ikot-Ekpene	C	68	68	–
			Opobo	C	28	90	62
			Arochuku	C	–	36	36
			Okit-Okoro	C	–	36	36
			Yigha	C	–	36	36
16	Cameroons	400,000	Victoria	A	110	180	70
			Tiko	C	130	130	–
			Buea	C	5	5	–
			Mamfe	C	60	90	30
			Kumba	C	74	90	16
			Bamenda	B	110	110	110
			Banso	C	–	90	90

17	Ijebu-Ode	350,000	Ijebu-Ode	B	68	178	110
			Shagamu	C	-	60	60
18	Ogoja	750,000	Ogoja	B	35	120	85
			Abakaliki	C	36	90	54
			Afikpo	C	-	60	60
			Obubra	C	31	61	30
19	Ondo	500,000	Akure	B	41	120	79
			Ado-Ekiti	C	-	60	60
			Ondo	B	-	120	120
			Ikare	C	-	60	60
			Okitipupa	C	-	60	60
20	Onitsha	1,000,000	Onitsha	B	63	180	117
			Enugu	A	72	180	108
			Nsukka	C	-	60	60
			Ihiala	C	-	60	60
21	Warri	500,000	Warri	B	26	176	150
			Forcados	C	24	60	36
			Kwale	C	-	60	60
			Sapele	B	31	91	60
22	Owerri	1,600,000	Port-Harcourt	A	130	210	80
			Aba	B	102	182	80
			Owerri	C	82	132	50
			Okigwi	C	76	120	44
			Umuahia	C	40	110	70
			Ahoada	C	-	60	60
			Degema	C	42	72	30
			Orlu	C	-	60	60
			Brass	C	-	36	36

23	Oyo	1,400,000	Ibadan	A	197	307	110
			Oyo	C	-	60	60
			Oshogbo	B	60	120	60
			Ife	C	-	60	60
			Iseyin	C	-	60	60
24	Lagos Colony	350,000	Lagos	A	246	600	354
			Ikorodu	C	-	36	36
			Badagry	C	-	36	36
			Epe	C	-	36	36
Total		21,050,000	13A		4,275	11,671	
			19B				
			80C				

Table compiled from Appendix I - Nigeria: Development of Medical and Health Services (1946) Development Plan)

APPENDIX B

Colonial Secretaries, 1919-1960

Viscount Milner	Jan. 1919	- Feb. 1921
Winston S. Churchill	Feb. 1921	- Oct. 1922
Duke of Devonshire	Oct. 1922	- Jan. 1924
J. H. Thomas	Jan. 1924	- Nov. 1924
L. C. M. S. Amery	Nov. 1924	- June 1929
Lord Passfield	June 1929	- Aug. 1931
J. H. Thomas	Aug. 1931	- Nov. 1931
Philip Cunliffe-Lister	Nov. 1931	- June 1935
Malcolm MacDonald	June 1935	- Nov. 1935
J. H. Thomas	Nov. 1935	- May 1936
W. G. H. Ormsby-Gore	May 1936	- May 1938
Malcolm MacDonald	May 1938	- May 1940
Lord Lloyd	May 1940	- Feb. 1941
Lord Moyne	Feb. 1941	- Feb. 1942
Vicount Cranborne	Feb. 1942	- Nov. 1942
O. F. G. Stanley	Nov. 1942	- Aug. 1945
G. H. Hall	Aug. 1945	- Oct. 1946
A. Creech Jones	Oct. 1946	- March 1950
James Griffiths	March 1950	- Oct. 1951
Oliver Lyttelton (Vicount Chandos)	Oct. 1951	- July 1954
Alan T. Lennox-Boyd	July 1954	- Oct. 1959
Iain Macleod	Oct. 1959	- Oct. 1961

APPENDIX C

Governors of Nigeria, 1919 - 1960

Sir Frederick Lugard	1914 - 1919
Sir Hugh Clifford	1919 - 1925
Sir Graeme Thompson	1925 - 1931
Sir Donald Cameron	1931 - 1935
Sir Bernard Bourdillion	1935 - 1943
Sir Arthur Richards	1943 - 1948
Sir John Macpherson	1948 - 1955
Sir James Robertson	1955 - 1960

APPENDIX D

Governors of the Gold Coast, 1920 - 1957

Brigadier - General F. G. Guggisberg	1919 - 1927
Sir Alexander Ransford Slater	1927 - 1932
Sir Thomas Shenton W. Thomas	1932 - 1934
Sir A. W. Hodson	1934 - 1941
Sir A. C. M. Burns	1941 - 1948
Sir Gerald H. Creasy	1948 - 1949
Sir Charles Noble Arden-Clarke	1949 - 1957

APPENDIX E

Governors of Sierra Leone, 1920 - 1961

R. J. Wilkinson	1916 - 1922
Sir A. R. Slater	1922 - 1927
Brigadier-Gen. Sir J. A. Byrne	1927 - 1931
Sir Arnold W. Hodson	1931 - 1934
H. Honck-Mason Moore	1934 - 1937
Sir Douglas Jardine	1937 - 1941
Sir Hubert Stevenson	1941 - 1948
George Beresford Stooke	1948 - 1953
Vice - Admiral Sir Robert Hall	1953 - 1957
Vice - Admiral Sir Maurice Dorman	1957 - 1961

APPENDIX F

Governors of the Gambia, 1920 - 1964

Captain C. H. Armitage	1920 - 1927
Sir John Middleton	1927 - 1928
Sir Edward Denham	1928 - 1930
Sir Herbert R. Palmer	1930 - 1933
Sir Arthur F. Richards	1933 - 1936
Sir Wilfrid Thomas Southern	1936 - 1942
Sir Hilary Blood	1942 - 1947
Sir Andrew Barkworth Wright	1947 - 1949
Sir Percy Wyn - Harris	1949 - 1958
E. H. Windley	1955 - 1962
J. W. Paul	1962 - 1964

APPENDIX G

Biographical notes on some members of the Colonial Office advisory Committees concerned with health and medicine in the colonial empire.

Sir James Kingston Fowler: He was consulting physician to the Middlesex Hospital; to King Edward VII Sanatorium, and Hospital for consumption, Brompton; president of the Medical Society of London; Dean of the faculty of medicine; member of senate of the University of London and Examiner in Medicine, University of Cambridge. Sir James was a member of the Colonial Advisory Medical and Sanitary Committee in the 1920s; Chairman of Committee for Colonial Medical appointments and chairman of the Yellow Fever committee (West Africa). He was noted for his interest in tuberculosis.

Sir John Rose Bradford: He was secretary of the Royal Society, 1908 to 1915; Chairman of University College Committee; president Royal College of Physicians, 1926 to 1931; member of the Senate, University of London; Emeritus Professor of Medicine University College Hospital and Holme Lecturer on Clinical Medicine to the University College Hospital Medical School. He was a member of the CAMSC and Senior Medical Consultant to the Colonial Office.

Sir Andrew Balfour: Director, Wellcome Tropical Research Laboratories, Khartoum, 1902 to 1913; Medical Officer of

Health, Khartoum, 1904 to 1913; Sanitary Adviser to the Sudan Medical Department; member, Medical Advisory Committee, Mediterranean War Area, 1916 to 1917; Scientific Adviser to Inspecting Surgeon-General, British Expeditionary Force, East Africa, 1917; President, Egyptian Public Health Commission, 1918; Health Commissioner, Mauritius, 1921 and Bermuda, 1923; President Royal Society of Tropical Medicine and Hygiene, 1925 to 1927; Director - in - chief, Wellcome Bureau of Scientific Research until 1923 when he was appointed Director, London School of Hygiene and Tropical Medicine. He was member of the CAMSC, CMRC (1927 to 1931) and MRC.

Sir George Seaton Buchanan: He entered the Local Government Board as Medical Inspector in 1895; acted as chief Inspector of Foods, 1900 to 1911; member of 1929 mission for the public health reorganization of Greece; President of the International Health Conference at Cape Town, 1932; Member of the court of Governors, London School of Hygiene and Tropical Medicine and member of the CAMSC..

Sir William Thomas Prout: Assistant Colonial Surgeon, Gold Coast, 1888; District commissioner, Gold Coast, 1890; Colonial Surgeon, Gambia, 1893; Principal Medical Officer, Sierra Leone, 1895; Honorary Physician, Hospital for Tropical Disease, London; Honorary Lecturer, School of Tropical Medicine, University of Liverpool; Senior consulting physician to the Colonial Office and member of the CAMSC.

Rt. Hon Sir Joseph West Ridgeway: Under secretary to the government of India in the Foreign Department, 1880 to 1884; Under secretary of Ireland, 1887 to 1893; Governor and commander - in -chief of Ceylon, 1896 to 1903; Chairman of Commission of Constitutional Enquiry, Transvaal and Orange River Colonies, 1906. He was member of the CAMSC in the 1920s.

Sir Walter Morley Fletcher: Lecturer, Natural Sciences, Trinity College, Cambridge, 1900 to 1914; Member of Army Pathology and Air Force Medical Advisory Committees; chairman of committee on the organization of medical research under the government of India and member of the CMRC.

Lt. Col. Sydney Price James: He was a member of the Indian Medical Service. He retired in 1918 and joined the Local Government Board as medical inspector and adviser on tropical disease; represented the British government in the League of Nations Epidemic Commission to Poland, 1922; member of the permanent Committee and president of the Yellow Fever Commission of the International Office of Public Health in Paris; member of the Malaria Commission of The League of Nations; he took part in 1923 to 1927 in inquiries on malaria in Russia and other countries of Europe, the near East and the United STates; deputed to India in 1927 as a member of The Fletcher Committee on the

organization of medical research; retired from the Ministry of Health in 1936 and joined The Moltena Research Institute Cambridge. He was a member of the Colonial Advisory Medical and Sanitary Committee.

Sir T. Drummond Shiels (M. P. and Physician): He was a member of Edinburgh Town Council; Member of Parliament (Labour) East Edinburgh, 1924 to 1931; member of special commission on Ceylon Constitution, 1927; Parliamentary under-secretary of State, Colonial Office, 1929 to 1931; member of governing body of British post-graduate medical federation and of the Colonial Secretarys Colonial Economic and Development Council. He was Chairman of the Colonial Development Public Health Committee, appointed in 1930.

Sir Basil Blackett: He was chairman of the Colonial Development Advisory Committee and member of the Colonial Development Public Health Committee. He had great experience and interest in imperial economic affairs; he was treasury official from 1904 to 1922; from 1922 to 1928 he was finance member of the government of India; from 1929, he became a businessman, directing companies such as De Beers, Eastern and Associated Telegraph Co. Ltd. and Cables and Wireless Ltd. In 1929 he became Director of the Bank of England. His interest in public health measures reflected his work as president of the British Social Hygiene Council.

Donald Breadal Bane Blacklock: Professor of Tropical Hygiene, University of Liverpool and Liverpool School of Tropical Medicine; Director of Runcorn Research Laboratory, 1913 to 1914; member of Expedition of Liverpool School of Tropical Medicine to Sierra Leone 1914 to 1915; Director of Alfred Jones Research Laboratory, Sierra Leone, 1921 to 1929. He was member of the Colonial Advisory Medical Committee.

Mary Georgina Blacklock (Physician): She had served briefly as a medical officer in Sierra Leone but she is best remembered for her work as an active member of the Medical Women's Federation in the 1930s. Among other things, The Federation was interested in the promotion of the work of medical women in the colonies, particularly with regard to women and children. In 1936 she was awarded a Leverhulme Scholarship to investigate the role of women in the medical and health services of the colonial empire. She reported in 1937. Mary Blacklock was the only female member of the Colonial Advisory Medical Committee.

Patrick Alfred Buxton: He was Director of the Department of Entomology, London School of Hygiene and Tropical Medicine since 1925, Professor of medical Entomology, University of London, since 1933, Entomologist to the government of Palestine, 1921 to 1923. He made many journeys to Africa investigating tsetse flies; member of the Medical Research Council. He was a member of the Colonial Medical Research Committee after the Second World War.

Brigadier Sir John Boyd: He served in many European wars; he was Director of pathology, War Office, 1945 to 1946. He retired in 1946. He became Director of Wellcome Laboratories of Tropical Medicine, 1946 to 1955; Wellcome Trustee, 1956 to 1966, and member of the CMRC, 1945 to 1960